STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325074	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manzano Del Sol by Purehealth	5201 Roma Avenue NE Albuquerque, NM 87108

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross reference to F756. Based on record reviews and interviews, the facility failed to keep a resident free from significant medication errors for 1 (R #25) of 1 (R #25) resident, when staff entered a duplicate medication order of clopidogrel (an antiplatelet; medication that prevents blood clots by preventing platelets in the blood from sticking together) and administered the clopidogrel for a period of 19 consecutive days. This deficient practice had the potential to cause severe complications including but not limited to severe bleeding and death. The findings are: A. Record review of Antiplatelet Drug Toxicity (when a drug causes harmful effects to the body due to various reasons such as overdosing), published in National Library of Medicine (NLM) and dated 06/12/23, revealed Antiplatelet Drug Toxicity can cause the following complications: - Intracranial hemorrhage (a life-threatening bleeding that occurs inside the skull when a blood vessel ruptures or leaks). - Gastrointestinal hemorrhage (blood loss from the digestive tract). - Retroperitoneal bleeding (when bleeding occurs in the space behind the lining of the abdomen). - Hemorrhagic shock (a life-threatening emergency where severe blood loss causes the body to lose too much blood volume to pump enough oxygen into the organs). B. Record review of R #25's Face Sheet revealed the resident was admitted to the facility on [DATE] with the following diagnoses: - Osteoporosis (a condition where bones become brittle and prone to breaking easily) with fracture (break) of left femur (a bone in the upper part of the left leg). - History of falling. - Anemia (low red blood cell count). - Transient ischemic attack (TIA, when blood flow to part of the brain stops for a brief period of time). C. Record review of R #25's Provider Orders revealed the following: - Dated 07/08/25, an active order for clopidogrel oral tablet, 75 milligrams (mg). Give one tablet by mouth every day in morning for cardiac (heart) health. - Dated 07/18/25 and entered by the Nurse Practitioner (NP), an active order for Plavix (a brand name of clopidogrel) oral tablet, 75 mg. Give one tablet by mouth every day at bedtime for atrial fibrillation (A-Fib; irregular heart rhythm). - Dated 07/18/25, Nurse #1 confirmed the Plavix order. - Both medication orders remained active between 07/18/25 and 08/05/25. D. Record review of R #25's Medication Administration Records (MARs) revealed the following: - Dated July 2025, staff administered the clopidogrel oral tablet 75mg and the Plavix 75 mg every day from 07/18/25 to 07/31/25. - Dated August 2025, staff administered the clopidogrel oral tablet 75mg and the Plavix 75 mg every day from 08/01/25 to 08/05/25. E. On 08/06/25 at 11:24 am, during an interview, Certified Medication Aid (CMA) #1 stated she worked morning shifts and administered R #25's morning dose of Plavix on 08/06/25. She stated she did not have access to the night shift medications list and could only view her shift's medications. She stated she was not aware R #25 received extra doses of Plavix during the night shift's medication pass. She stated giving extra doses of Plavix was considered over-medicating and could cause bleeding. F. On 08/06/25 at 11:34 am, during an interview, Nurse #1 stated she confirmed the Plavix order was dated 07/18/25, but she did not review R#25's current medications. She stated reviewing current medications was not part of the confirmation process. She stated giving an extra dose of Plavix could cause bleeding. H. On 08/06/25 at 11:53 am, during an interview, the Director of Nursing (DON) stated she expected the Nurse Practitioner to discontinue the original order when she entered a new order. She stated reviewing R #25's current medications when (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	confirming new orders was not part of the confirmation process conducted by the nurses. I. On 08/06/25 at 12:26 pm, during an interview, the Nurse Practitioner stated she entered a new order in R #25's Electronic Health Record (EHR) for Plavix and did not stop the original clopidogrel order. She stated she wanted to change the Plavix's administration time to be during the evening medication pass instead of the original administration time during the morning medication pass. She stated she did not discontinue the original order. She stated giving an extra dose of Plavix could cause bleeding. J. On 08/06/25 at 1:32 pm, during an interview, R #25 stated she was not aware she received a double dose of Plavix for 19 consecutive days. She stated she always received Plavix once a day before she was admitted to the facility. Based on record reviews and interviews, an Immediate Jeopardy (IJ) was identified to have occurred on 07/18/25 when the NP entered a duplicated order of Plavix for R #25. The facility Administrator was notified in person on 08/06/25 at 4:10 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 08/06/25 at 2:00 pm. Plan of Removal Corrective Action: - Residents clopidogrel has been discontinued as of 8/6/2025. Stat labs have been ordered for the resident. Nurse practitioner will assess resident 8/7/2025 and skin check has been completed. - Pharmacy completed medication order review audit for all residents on 8/6/2025. - The Medical Director will educate all providers on order review when entering new orders or changing orders. Compliance date 8/7/2025. - The physician orders will be confirmed by nursing staff based on the Standard Operating Procedure. Re-education of the SOP will be completed by 8/8/2025. - To monitor ongoing compliance, the IDT team will incorporate a daily audit of orders confirmed to ensure compliance in our daily clinical meeting. Nurse management will audit the medication orders for 5 residents weekly x4, monthly x2 to ensure compliance and report findings to the QAPI committee. - Date of compliance 8/8/2025. Implementation of the POR was verified onsite on 08/08/25, and the IJ was removed on 08/11/25 at 2:22 pm. The scope and severity was reduced from a J to an E. Implementation of the POR was verified by the following: - Record review of R #25's Provider Orders, date 08/06/25, showed the NP discontinued the clopidogrel order. - Record review of R #25's Progress Notes revealed the following:- Dated 08/06/25, Nurse #1 completed R #25's skin assessment with no concerns or complications. - Dated 08/07/25, the NP completed R #25's assessment. R #25 showed no side effects from receiving a duplicated dose of Plavix. - Record review of the facility's All Residents' Medication Orders Audit, dated 08/06/25 and completed by Consultant Pharmacist, showed residents did not have any irregularities in medication orders reviewed. - Record review of R #25's Lab Report, dated 08/07/25, showed R #25's Complete Blood Count (CBC; determines general health status, screens for, and monitors for a variety of disorders to include anemia) and platelets were within normal limits. - On 08/08/25 at 2:41 pm, during an interview, the Nurse Practitioner (NP) stated she received the provider's email on the process of prescribing new medication orders. She stated she was aware she should enter medication orders in residents' Electronic Health Record before leaving the building in order to avoid order duplication. The NP stated she should not use abbreviations when entering medication orders. - On 08/08/25 at 2:41 pm, during an interview, Attending Physician stated he received the provider's email on the process of prescribing new medication orders. He stated he should enter medication orders in residents' Electronic Health Record before leaving the building in order to avoid order duplication. The AP stated he should not use abbreviations when entering medication orders. - On 08/08/25 at 2:53 pm, during an interview, Nurse #1stated she had training on new orders confirmation process. She stated she should review residents' current medication orders before confirming new orders. She stated she should report any duplicate orders to the Unit manager, DON, and alert the pharmacy staff. - On 08/08/25 at 2:55 pm, during an interview, Nurse #2 stated he had training on new orders confirmation process. He stated he should review residents' current medication orders before confirming new orders. - On 08/08/25 at 3:09 pm, during an interview, Nurse #3 stated she had training on new orders confirmation process. She stated she should review medications route (the way a medicine is given), dose, and any duplicates. Nurse #3 stated she should (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ask the prescribing provider if she noticed any concerns with new orders. - On 08/08/25 at 3:19 pm, during an interview, Nurse #4 stated she had training on new medication orders confirmation process. She stated she was aware she should review current residents' medications before confirming new orders.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Cross reference to F756, F868 and F880. Based on record review and interviews, the facility failed to ensure the Medical Director (MD) participated in the Quality Assurance and Performance Improvement (QAPI; a structured framework used in healthcare to enhance the quality of care provided to patients), the Infection Prevention and Control Program (IPCP, a set of strategies and practices designed to prevent and control the spread of infections in healthcare settings), and the Medication Regimen Review (MRR) program. This failure had the potential to affect all residents at the facility. If the MD does not participate in QAPI, Infection Control, and MRR to assist in identifying, prioritizing, and correcting quality deficiencies, then the facility cannot ensure quality of care and services are consistently monitored and improved. The findings are: A. On 08/06/25 at 11:15 am, during an interview, the Nurse Practitioner stated she reviewed the facility's monthly MRRs. She stated she did not consult the Attending Physician when she responded to and acted on the Pharmacist's recommendations. B. On 08/08/25 at 2:41 pm, during an interview, the Attending Physician stated he did not review the facility's monthly MRRs or act on them. He stated the Nurse Practitioner did it. C. On 08/08/25 at 1:50 pm, during an interview, the Administrator stated she expected the Medical Director to review the facility's monthly MRRs or to instruct the Attending Physician to review them. D. On 09/11/25 at 1:31 pm, during an interview, Medical Director stated she expected the Attending Physician to review MRRs. The Medical Director stated she should have provided an oversight on the MRR process in the facility, and she should have instructed the Attending Physician to review MRRs instead of Nurse Practitioner.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and staff interviews, the facility failed to ensure the Medical Director participated in the Quality Assurance and Performance Improvement/Quality Assurance and Assessment (QAPIQAA) Committee meetings, as required by regulation. This failure had the potential to affect all residents. If the facility does not ensure required members, including the Medical Director (MD), participate in the QAPI/QAA Committee, then the committee may not fully meet regulatory requirements for oversight of quality issues. The findings are:A. Record review of the facility's QAPI Program policy, revised September 2024, stated the QAPI/QAA Committee met monthly to review reports, evaluate data, and monitor QAPI activities. Committee membership included the Administrator, Director of Nursing, Medical Director, and at least three other staff members from different disciplines. The committee was responsible to identify quality deficiencies, develop corrective actions, and ensure ongoing compliance. B. Record review of the facility's QAPI plan, dated January 2025, showed the MD was designated as a standing member of the QAPI committee with responsibility for participation in monthly meetings. C. Record review of the facility's QAPI/QAA committee rosters showed the MD did not attend any QAPI meetings since September 2024. D. On 08/07/2025 at 12:44 PM, during an interview, the Nurse Practitioner stated she never saw the MD attend a QAPI meeting. E. On 08/11/2025 at 9:45 AM, during an interview, the Administrator stated the last time the MD attended a QAPI meeting was in September 2024. She stated the MD did not attend any monthly or quarterly QAPI meetings since September 2024. She stated the MD has Calander invites along with all staff to attend the monthly meetings along with the quarterly meetings. F. On 08/06/25 at 1:17 pm, 08/14/25 at 11:27 am, and 08/15/25 at 10:05 am, phone calls were made to the MD and call back messages for an interview were left; however, the MD did not respond to the requests for an interview.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews and record reviews, the facility failed to ensure an effective Infection Prevention and Control program (IPCP, a set of strategies and practices designed to prevent and control the spread of infections in healthcare settings) when the facility's Medical Director (MD) failed to attend the scheduled infection control monthly meetings or be part of the program. This failure had the potential to affect all residents. If the MD does not participate in the facility's infection control program, then residents may be at an increased risk of infections due to a delay in identification and response of outbreaks. The findings are: A. Record review of the facility's Infection Control Online Meeting Invitations, dated 01/28/25, 02/04/25, 02/25/25, 03/25/25, 04/22/25, 05/27/25, and 07/16/25, revealed the MD did not participate in any of the meetings. B. On 08/08/25 at 11:04 am, during an interview, the Infection Control Preventionist (ICP) stated he worked for the facility for nine months and did not meet the MD at any of the Infection Control Meetings. The ICP stated he was not aware the MD was part of the IPCP. He stated he did not communicate with the MD or the attending physician for issues related to the IPCP. C. On 08/08/25 at 1:50 pm, during an interview, the Administrator stated she expected the MD to attend the Infection Control Meetings and be part of the IPCP.D. On 08/06/25 at 1:17 pm, 08/14/25 at 11:27 am, and 08/15/25 at 10:05 am, phone calls were made to the MD and call back messages for an interview were left; however, the MD did not respond to the requests for an interview.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hazardous chemicals were stored securely and remained inaccessible to 4 (R #13, R #41, R #46 and R #55) out of 4 (R #13, R #41, R #46 and R #55) residents. If hazardous chemicals are left unattended and accessible to residents with significant cognitive impairments, then residents are at risk for accidental ingestion, misuse, or chemical contact injuries, which can result in serious harm. The findings are: A. Record review of the facility's Hazardous Areas, Devices and Equipment policy (dated 08/12/25) stated the following:- Hazardous areas, devices, and equipment in the facility would be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible.- Hazardous areas included access to toxic chemicals.-Any element of the resident environment that has the potential to cause injury and was accessible to a vulnerable resident was considered hazardous.- Vulnerable residents would be identified based on functional status, medical condition, and cognitive abilities. Measures such as locks, alarms, and supervision would be implemented to ensure hazardous areas and items are not accessible to them. B. On 08/08/25 at 1:41 PM, observation revealed a container of bleach disinfectant wipes sat on a banister in the common area, and four residents sat nearby. Staff were not present in the area. R #13, R #41, R #46 and R #55 sat in their wheelchairs and watched television. C. On 08/08/25 at 1:42 PM, during an interview, Certified Nurse Aide (CNA) #1 stated the wipes should not be left out. She stated a resident could grab them and use them to wipe their face. D. On 08/08/25 at 1:59 PM, during an interview, Registered Nurse (RN) #2 stated the wipes should not be left out. She stated residents could use them improperly and unintentionally harm themselves. E. On 08/11/25 at 1:21 PM, observation revealed a container of bleach disinfectant wipes sat on a banister in the common area, and R#41 and R #55 sat nearby. Staff were not present in the area. F. Record review of R #55's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 07/02/25, revealed a diagnosis of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with cognitive impairment affecting decision-making, memory and safety awareness. R #55 Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) was 8, moderately impaired. G. Record review of R #13's MDS, dated [DATE], revealed a diagnosis of unspecified dementia with severe cognitive impairment affecting judgment, understanding, and communication. R #13 required extensive assistance with all activities of daily living. R #13's BIMS score was not determined, because the resident was rarely/never understood. H. Record review of R #41's MDS, dated [DATE], revealed a diagnosis of vascular dementia with impaired decision-making and hazard recognition. R#41's BIMS score was not determined, because the resident was rarely/never understood. I. Record review of R #46's MDS, dated [DATE], revealed diagnoses of Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior) and vascular dementia with severe cognitive impairment. R #46's BIMS score was not determined, because the resident was rarely/never understood. J. On 08/11/25 at 1:22 PM, during an interview, the Director of Nursing (DON) stated it was her expectation that staff would not leave bleach wipes out. She stated residents could use the wipes as wet wipes or put them in their mouths. She stated staff should never leave the wipes out. K. On 08/11/25 at 1:30 PM, during an interview, the Administrator stated it was her expectation staff would put all cleaning chemicals away after use. She stated it was a hazard to have the wipes out, because the residents could use them on their faces or in the restroom.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide routine and emergency dental services for 2 (R #4 and R #48) of 2 (R #4 and R #48) residents. If the facility does not ensure residents with identified dental pain are referred for prompt evaluation and treatment, then residents are at risk for unresolved oral pain, infection, poor nutrition, and overall decline in health and quality of life. The findings are: R #4 A. Record review of R #4's face sheet showed she was admitted to the facility on [DATE] with a diagnosis of stage three chronic kidney disease and type two diabetes. B. On 08/05/25 at 10:38 AM, during an interview, R #4 stated she did not have a dental appointment in a long time. She stated she was supposed to have dental appointments every six months, because she was on dialysis (a medical treatment which filters waste and excess fluid from the blood). C. On 08/06/25 at 2:15 PM, during an interview, Social Services stated she did not have anything to do with making any type of appointments. She stated the Patient Access Representative was the one who made the resident's appointments. D. On 08/06/25 at 2:23 PM, during an interview, the Patient Access Representative/Appointment Scheduler stated she had R #4 on her list to schedule a dental appointment. She stated R #4 went to the dentist every six months, but the resident went to the hospital when her last appointment was scheduled. The Patient Access Representative/Appointment Scheduler stated she should have rescheduled the resident's appointment right away, but she did not. E. Record review of R #4's care plan, dated 12/31/24, revealed an oral/dental health problem initiated and resolved on the same date. The resident did not have any current active dental or oral health problems or interventions. F. On 08/11/25 at 10:50 AM, during an interview, the Administrator stated oral care should be care planned. The Administrator stated residents who did not receive routine dental care could be at risk for complications due to poor dental hygiene. R #48 G. Record review of R #48's face sheet revealed an admission date of 01/28/2008 with the following diagnoses: -Hemiplegia and hemiparesis (weakness on one side of the body) -Diabetes mellitus (DM; a disease in which the body cannot make or properly use insulin). -Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) H. Record review of R#48's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/14/25, revealed a Brief Interview for Mental Status (BIMS; a (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	screening for cognitive impairment) score of 3, severe cognitive impairment. I. On 08/05/25 at 2:47 PM, during an interview, R #48 pointed to his front teeth and stated, hurt. J. Record review of R #48's progress notes revealed the progress notes did not contain any documentation of a dental referral, assessments, or appointments related to the resident's reported oral pain. K. On 08/10/25 at 2:46 PM, during an interview, Registered Nurse (RN) #3 stated he heard R #48 say his mouth hurt. He stated he did not document the resident's pain in the resident's progress notes. K. On 08/11/25 at 9:32 AM, during an interview, the Administrator stated staff did not make a dental appointment for R #48 following his complaint of mouth pain. She stated the resident's record did not show the resident had a dental appointment.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure residents maintained a dignified existence when staff failed to assist a resident with arranging grooming services for 1 (R #50) of 1 (R #50) resident reviewed for resident rights. This deficient practice limits the residents' ability to maintain dignity, personal appearance, and quality of life and had the potential to affect all residents who relied on facility staff to arrange grooming services. If the facility fails to assist residents in arranging grooming services, this could impact the resident's dignity, potentially leading to or worsening depression. The findings are: A. Record review of the facility's Resident Rights policy, revised August 2024, stated the residents had a right to privacy, dignity, and self-determination in their care. B. Record review of facility's Dignity Policy, undated, revealed the following:- Each resident shall be cared for in a manner which promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.- When assisting with care, residents were supported in exercising their rights. Residents were groomed as they wished to be groomed, including hair styles, nails, facial hair, etc. C. Record review of R #50's Face Sheet, dated 08/08/2025, revealed the following:-The resident admitted on [DATE].-The resident had a diagnosis of assistance with personal care. -The resident had a diagnosis of major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). D. During an observation of R #50, the resident's hair appeared multicolored, with the previous dye color grown out. The resident's hair lengths were uneven, with some areas longer than others. E. Record review of R #50's Care Plan, dated 04/01/2024, revealed the following:-Resident used antidepressant medication related to self isolation and decreased interests in activities.-Attempt nonpharmacological interventions.-Care plan did not address personal hygiene or grooming. F. Record review of R #50's Care Conference notes revealed the following: -Dated 08/19/2021, Social Services will provide a schedule and contact information for the facility's contracted beautician.- Dated 11/02/2023, Social Services to contact the facility's contracted beautician. G. On 08/08/25 at 10:27 AM, during an interview, R #50 stated she did not receive a haircut in two years and wanted assistance arranging beautician services. The resident stated she was depressed and having her hair colored and cut would make her feel better. The resident stated her hair was a mess and she was embarrassed by her appearance. The resident stated the beautician charged a fee for the haircut, but she was willing to pay out-of-pocket for the services. R #50 stated her previous hospice company offered to arrange for her hair to be colored but she was not a resident of the hospice company any longer. R #50 stated she called the facility's beautician and left multiple voicemails, without receiving a return call. She stated a staff member told her the facility's beautician did not provide services to residents in wheelchairs. She stated the Social Services Department told her only residents who could walk, sit in her chair, and sign themselves up or have a family member assist received beautician services. H. On 08/18/2025 at 3:11 PM during an email interview, the Administrator stated the Social Services (SS) Department discussed beautician services with the resident. The Administrator stated SS arranged the appointments once a request was submitted. The Administrator stated SS reported there were not any residents at the facility who were denied beautician services by the facility contracted beautician. The Administrator stated residents could request beautician services or a family members could request beautician services for them. She stated the facility maintained a sign-up sheet for beautician and barber services for long-term care residents. The Administrator stated the Beautician was unaware of any long-term residents who was denied beautician/barber services. The Administrator stated residents who used wheelchairs could access the beautician, and she was not aware of any long-term care residents denied beautician or barber services. She stated the facility (continued on next page)

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	325074	A. Building B. Wing	08/11/2025

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Manzano Del Sol by Purehealth	5201 Roma Avenue NE Albuquerque, NM 87108

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supported resident dignity and grooming by setting up appointments upon resident request and discussing grooming options during care conferences.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure a resident's current advanced directive (a document which provides an individual's wishes for emergency and lifesaving care) was properly documented for 1 (R #7) of 1 (R #7) resident. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #7's Face Sheet, undated, revealed the following: -admission date of 11/18/2022.-Resident was a Full Code (attempt resuscitation). B. Record review of R #7's Medical Orders for Scope of Treatment (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves), dated 04/18/2024, revealed the following: - Code status of do not resuscitate (DNR; lifesaving measures are not desired). - Comfort measures.- Do not transfer to hospital unless comfort needs cannot be met in current location.- Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. C. Record review of R #7's Progress Notes, dated 08/03/25, revealed the resident's code status was attempt Full Code. Comfort measures: Do not transfer to hospital unless comfort needs cannot be met in current location. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. D. Record review of R#7's Care Plan, dated 12/27/24, revealed the resident's Care Plan did not include an Advanced Directive. E. Record review of R #7's Care Conference, dated 01/15/25, revealed the resident's code status was Full Code. F. On 08/06/25 at 12:24 PM, during an interview, R #7 stated his code status was full code, and his wishes were to be resuscitated with comfort measure to relieve pain. G. On 08/08/25 at 2:56 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated R #7's physician orders indicated Full Code, and the resident's MOST form indicated the resident was DNR. LPN #1 stated she would follow the MOST form located in the binder at the nurses' station which was DNR. H. On 08/11/25 at 10:50 AM, during interview, the Administrator stated R #7's code status was Full Code, and the resident's MOST form indicated DNR. She stated MOST forms were kept at the first and second floor nurses' stations. The Administrator stated the resident's most recent care plan did not document an advanced directive. The Administrator stated failure to follow the correct code status could potentially cause harm to the resident. She stated Social Services and Nurse Management reviewed advanced directives quarterly. The Administrator stated it was her expectation advanced directives were accurate and honored the residents' wishes.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 1 (R #66) of 1 (R #66) resident, when staff failed to ensure the resident's as needed (PRN) alprazolam (anti-anxiety medication) was prescribed for a limit of 14 days, unless there was documentation in the resident's medical record of the rationale to extend beyond 14 days. This deficient practice could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result).The findings are:A. Record review of the facility's Medication Review Regimen (MRR) policy, undated, revealed the following:- The consultant pharmacist reviewed the medication regimen of each resident at least monthly.- Resident-specific irregularities resulting from or associated with medications were documented in the resident's active record and reported to the Director of Nursing (DON), Medical Director, and Attending Physician (AP).- Recommendations were acted upon and documented by the facility staff and/or the prescriber.- Prescriber accepted and acted upon suggestion or rejected and provided an explanation for disagreeing.- The policy did not state PRN orders for psychotropic medications were limited to 14 days. B. Record review of the facility's Psychotropic Medication Use, dated September 2024, revealed PRN orders for psychotropic medications were limited to 14 days. C. Record review of R #66's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:- Muscle weakness (reduction in the power exerted by muscles),- Unsteadiness on feet (a lack of stability or coordination while walking or standing),- Cognitive communication deficit (difficulties in communication),- Need for assistance with personal care (a person requires help with daily tasks related to hygiene, grooming, and overall self-care),- Displaced intertrochanteric fracture of left femur (a break in the upper part of the left thigh bone, femur). D. Record review of R #66's Physician Orders Sheet dated 07/29/25, revealed an active order to administer alprazolam, 0.25 milligram (mg) tablet. Give one tablet every 24 hours by mouth PRN for anxiety. The order had a stop date of indefinite. E. Record review of R #66's MRR, dated 07/30/25, revealed the Pharmacist Consultant (PC) recommended limiting the use of alprazolam to a 14-day duration. The Attending Physician did not respond to PC's recommendations. F. On 08/08/25 at 1:50 pm, during an interview, the Director of Nursing (DON) stated she expected R #66's attending physician to enter a 14-day stop date for the psychotropic medication order. The DON stated she did not expect the nurses to review order end dates on psychotropic orders being confirmed. G. On 08/08/25 at 2:41 pm, during an interview, R #66's Attending Physician stated he visited and reviewed R #66's medications once a month. He stated he was not aware PRN psychotropic medications orders needed a 14-day stop date. H. On 08/11/25 at 11:33 am, during an interview, the PC stated he expected R #66's AP to enter a 14-day stop date for the alprazolam order.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to complete and submit a Five Day Report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations) to the State Agency regarding allegations of neglect (the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress) for 1 (R #77) of 1 (R #77) resident. If the facility does not submit follow-up reports, then the State Agency cannot assure the residents are safe and free of neglect. The findings are:A. Record review of R #77's Face Sheet revealed an initial admission date of 06/20/25 with the following diagnoses:- Cardiomyopathy (heart disease),- Type 2 diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar),- Unspecified Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),- Hypoxemia (low levels of oxygen in the blood),- Atherosclerosis heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls). B. Record review of the facility's Facility Reported Incident (FRI), dated 06/24/25, revealed R #77 fell shortly after admission on [DATE] and fell again later that evening. The FRI did not report the time of the falls. The FRI documented R #77 complained of pain on 06/24/25, which resulted in the diagnosis of a right femoral neck fracture (a break in the neck of the right thigh bone, located just below the ball of the right hip joint). C. Record review of R #77's Electronic Health Record, revealed R #77 was discharged to the hospital on [DATE]. Further review revealed the facility did not document any evidence the facility completed an investigation into the resident's falls or fracture of the right thigh. D. On 08/07/25 at 1:50 pm, during an interview, Director of Nursing (DON) stated she did not complete an investigation into the resident's falls, because the resident did not return to the facility after being hospitalized . The DON stated she was aware the Five Day Follow-Up report was due on the fifth day after an incident was reported to the State Agency.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment of a resident's functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 2 (R #6 and R #23) of 2 (R #6 and R #23) residents. If staff do not complete an accurate assessment of residents, then staff may not provide adequate care and treatment of the resident's needs. The findings are: R #6 A. Record review of R #6's Face Sheet, undated, revealed the following: -Resident admission date of 06/14/2023.-Primary diagnosis of Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior).-Diagnosis of atrial fibrillation (A-Fib; irregular heart rhythm). B. On 08/07/25 at 1:29 PM, during an observation, revealed R #6 had missing and broken teeth. C. Record review of R #6's Care Plan, dated 02/12/24, revealed oral care was not care planned. D. Record review of R #6 annual MDS, dated [DATE], revealed the following: -Resident was dependent on staff for oral hygiene. -Resident did not have natural teeth. E. Record review of R #6's Progress Notes, dated 02/20/25, revealed the Director of Nursing (DON) documented R #6 had problems with teeth. The record did not state what kind of problems the resident had with their teeth. G. On 08/18/25 at 10:34 AM, during an interview with DON, she stated R #6 had natural teeth. The DON stated she could not recall what problems the resident experienced in the resident progress notes, dated 02/20/2025. The DON stated the Annual MDS dated , 06/07/2025, was coded correctly. The DON stated she was responsible for the review and accuracy of the MDS. R #23 H. Record review of R #23's Face Sheet, undated, revealed and admission date of 04/30/2024 with the following diagnoses:- Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease) - Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body).- Cerebral infarction (stroke). I. Record review of R #23's Annual MDS, dated [DATE], revealed the resident had clear speech. J. Record review of R #23's Care plan, dated 05/08/24, revealed the following: -Resident had communication problem. -Resident responded to yes/no questions appropriately and used a communication board. -Monitor/document for physical/nonverbal indicators of discomfort or distress. -Resident will communicate non-verbally her feelings related to emotional state. -Resident will maintain daily routine of communicating nonverbally. K. On 08/05/25 at 10:06 AM during an observation, R #23 was nonverbal. L. On 08/05/25 at 10:30 AM during an interview, Dietary Aide #1 stated R #23 was nonverbal and could answer simple questions by moving her head yes, no or with thumbs up, thumbs down. M. Record review of R #23's Progress Notes revealed the following: - Dated 03/04/25, resident was nonverbal and communicated by nodding her head yes and no and used a thumbs up gesture. - Dated 04/23/25, resident had a diagnosis of aphasia. The resident did not verbally communicate but pointed to express herself. The resident appeared to be able to interact non-verbally, as evidenced by waving at others.- Dated 07/02/25, resident had a diagnosis of aphasia due to cerebrovascular disease, which likely contributed to her non-verbal status. - Dated 08/10/25, social history was unobtainable at this time secondary to resident's nonverbal status. O. Record review of R #23's Social Services Assessment, dated 05/03/24, revealed resident was non-verbal due to stroke. P. On 08/18/25 at 10:34 AM, during an interview, the DON stated R #23 was nonverbal. The DON stated the Annual MDS, dated [DATE], was incorrectly coded, and facility staff should have coded the resident's MDS as the resident did not speak. The DON stated she was responsible for the review and accuracy of R #23's Annual MDS.

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	325074	A. Building B. Wing	08/11/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to develop and implement a complete baseline care plan within 48 hours of admission for 1 (R #73) of 1 (R #73) resident. If the facility fails to implement a complete baseline care plan within 48 hours of admission for residents, then the resident may be at risk of serious falls, hospital transfers, and worsening of clinical status. The findings are: A. Record review of the facility's Care Plans- Baseline Policy, dated 08/2024, revealed a comprehensive care plan may be used in place of the baseline care plan, provided the comprehensive care plan was developed within 48 hours of the resident's admission. B. Record review of R #73's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:- Muscle weakness (reduction in the power exerted by muscles),- Unsteadiness on feet (a lack of stability or coordination while walking or standing),- Cognitive communication deficit (difficulties in communication),- Need for assistance with personal care (a person requires help with daily tasks related to hygiene, grooming, and overall self-care). C. Record review of R #73's medical record revealed the facility did not develop the resident's care plan within 48 hours of admission (due 08/03/25). The resident's baseline care plan was dated 08/04/25. D. On 08/07/25 at 11:44 am, during an interview, the Unit Manager (UM) #2 stated any resident admitted late Friday afternoon or over the weekend would have a baseline care plan completed on the following business day. UM #2 stated it was her expectation for Unit Managers to complete the baseline care plans. She stated floor nurses were not expected to do resident care plans. She stated floor nurses were not in the habit of making care plans, because Unit Managers did them per Director of Nursing's (DON) directive. UM #2 stated she could not provide a reason why R #73's baseline care plan was not completed within 48 hours. She stated she did not work on the weekends. She stated her records showed R #73 was admitted to facility at 6:01 pm on Friday, 08/01/25. E. On 08/08/25 at 1:50 pm, during an interview, the DON stated nursing leadership was responsible to create baseline care plans and comprehensive care plans. She stated floor nurses did not have the time to create care plans for the residents and were not efficient at doing care plans. She stated there were not any expectations for weekend staff to cover Friday admissions, and the nurse leadership would complete the care plans on the following business day. The DON stated she did not know when the 48 hour time frame would start to complete basic care plans, and she was not aware weekends counted towards the timeframe.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement resident focused, comprehensive care plans to address the oral hygiene needs for 1 (R #6) of 1 (R #6) resident. This deficient practice is likely to place the residents at risk for inadequate routine dental care, pain, infection, and complications to underlying conditions and prescribed medications. The findings are:A. Record review of R #6's Face Sheet, undated, revealed the following: -Resident admission date of 06/14/2023. -Primary diagnosis of Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior). -Diagnosis of atrial fibrillation (A-Fib; irregular heart rhythm). B. On 08/09/25 at 11:35 AM, during an observation, R #6's front teeth were missing. C. Record review of R #6's Progress Notes, dated 04/08/25, revealed the following: -Staff did not perform oral care for the resident. Resident independent in oral care. -The resident experienced disorganized thinking. -The resident had severe cognitive impairment. D. Record of R #6's Progress Notes, dated 02/25/25 revealed the resident experienced problems with their teeth. E. Record review of R #6's Care Plan, dated 06/23/2023, revealed the care plan did not address dental services or oral care. F. On 08/11/25 at 10:50 AM, during an interview, the Administrator stated R #6 did not receive dental services since admission to the facility. The Administrator stated it was her expectation for resident's oral care to be care planned, so the resident could receive routine dental services. The Administrator stated the resident could be at risk for complications due to poor dental hygiene if residents did not have oral hygiene and services care planned. G. On 08/18/25 at 10:34 AM, during an interview, the Director of Nursing (DON) stated residents did not require a care plan for dental services or oral hygiene. She stated dental/oral hygiene care planning would be created if the resident had an infection or other issues with the oral cavity. The DON stated staff who provide direct resident care can access the residents' care plan for dental hygiene under activities of daily living. The DON stated the nursing department was responsible to create and update each residents' care plan. She stated R #6 did not have a plan for dental services or oral hygiene anywhere in the care plan.

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	325074	A. Building B. Wing	08/11/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross reference to F760 and F605. Based on record reviews and interviews, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met for 1 (R #66) of 1 (R #66) residents reviewed for unnecessary medications when the Attending Physician (AP) and the Medical Director (MD) failed to review, respond to, and act on the Consultant Pharmacist (CP)'s identified irregularities (the use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and that impedes or interferes with achieving the intended outcomes of pharmaceutical services) sent monthly via Medication Regimen Reviews (MRRs, pharmacy review of the medication a resident receives). If physicians do not review, respond to, and act on CP's identified irregularities, then it could result in adverse consequences related to medication therapy. The findings are:A. Record review of the facility's Medication Utilization and Prescribing - Clinical Protocol policy, dated 08/2024, revealed the Consultant Pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that were not supported based on clinical signs or symptoms. B. Record review of the facility's MRR policy, undated, revealed the following:- The Consultant Pharmacist performed a comprehensive review of each resident's medication regimen and clinical record at least monthly. - The Consultant Pharmacist identified irregularities (the use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, or impedes/interferes with achieving the intended outcomes of pharmaceutical services) through a variety of sources, including the resident's clinical record, pharmacy records, and other applicable documents. C. Record review of R #66's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:- Muscle weakness (reduction in the power exerted by muscles),- Unsteadiness on feet (a lack of stability or coordination while walking or standing),- Cognitive communication deficit (difficulties in communication),- Need for assistance with personal care (a person requires help with daily tasks related to hygiene, grooming, and overall self-care),- Displaced intertrochanteric fracture of left femur (a break in the upper part of the left thigh bone, femur). D. Record review of R #66's Physician Orders Sheet, dated 07/29/25, revealed an active order to administer alprazolam (anti-anxiety medication) 0.25 milligram (mg) tablet. Give one tablet every 24 hours by mouth as needed (PRN) for anxiety. The order had a stop date of indefinite. E. Record review of R #66's MRR dated 07/30/25, revealed the Pharmacist Consultant (PC) recommended limiting the use of alprazolam to a 14-day duration. The Attending Physician did not respond to Pharmacist Consultant's recommendations. F. On 08/08/25 at 2:41 pm, during an interview, R #66's Attending Physician stated he visited and reviewed R #66's medications once a month. He stated he was not aware PRN psychotropic medications orders needed a 14-day stop date. G. On 08/11/25 at 11:33 am, during an interview, the Pharmacist Consultant stated he expected R #66's AP to enter a 14-day stop date for the alprazolam order.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and staff interviews, the facility failed to: - Ensure resident refrigerators were maintained in a clean and sanitary condition. - Label and date food items in the refrigerators. This failure had the potential to affect 1 (200-unit) out of 1 (200-unit) unit refrigerators. If the facility does not maintain refrigerators in a safe and sanitary manner, then residents are at risk of consuming spoiled or contaminated food, which could result in foodborne illness or decline in health.The Findings are:A. Record review of the facility's policy titled Food Storage and Sanitation, revised April 2024 ,revealed the following:- All food items stored in resident refrigerators were to be labeled and dated upon placement.- Refrigerators would be cleaned on a scheduled basis and kept free of spills, grime, and food residue.- Staff were responsible for monitoring to ensure food storage and appliances remained sanitary and safe for resident use. B. On 08/05/2025 at 8:30 AM, during an observation, the interior of the 200-unit resident refrigerators located in the common area was grimy, sticky, and had brown fluid pooled on the bottom under the clear drawers. Further observation revealed an unopened can of V8 juice, two Sprite zeros, and eight unopened pudding packs which were not labeled with a resident's name. C. On 08/11/2025 at 1:17 PM, during an interview, the Unit Manager stated the refrigerators should be cleaned, and all food should be labeled with resident name. D. On 08/11/2025 at 2:00 PM, during an interview, the Administrator stated it was her expectation for all items in the resident refrigerators to be labeled with the resident's name. She stated the refrigerator should be clean and free from dirt or spills.