

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Fiesta Park Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8820 Horizon Boulevard NE Albuquerque, NM 87113	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review 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 1 (R #2) of 1 (R #2) resident reviewed for MDS accuracy. This deficient practice could result in failure to provide adequate care and treatment of the resident's needs. The findings are: A. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE] with the following diagnoses: Guillain-Barre syndrome (a rare condition where the body's immune system attacks the nerves), Epilepsy (a long-term brain disorder that causes repeated, unprovoked seizures due to abnormal electrical activity in the brain), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R #2 was discharged to the hospital on [DATE]. B. Record review of R #2's Change in Condition (CIC) form, dated 10/16/25, revealed R #2 was unable to transfer out of bed and sent to the hospital. C. Record review of R # 2's Progress Note, dated 10/16/25, revealed R #2 was transported via ambulance to the hospital. D. Record review of R # 2's Discharge MDS, dated [DATE], revealed staff did not document a discharge destination. E. On 02/20/26 at 3:33 PM during an interview, the Director of Nursing (DON) stated R #2 was scheduled to discharge from the facility on 10/16/25. She stated R #2 experienced abdominal pain and was sent to the hospital for an evaluation. F. On 02/20/26 at 3:58 PM during an interview, the MDS Coordinator (MDSC) stated she was responsible for completing R #2's MDS assessments. She stated R #2's MDS, dated [DATE], was inaccurate because R #2's discharge destination was left blank. The MDSC stated R #2 was discharged to the hospital. The MDSC stated it was her expectation all MDS assessments be coded accurately.</p>

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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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) was accurate for 9 (R #2, R #3, R #5, R #6, R #7, R #8, R #9, R #10, and R #11) out of 9 (R #2, R #3, R #5, R #6, R #7, R #8, R #9, R #10, and R #11) residents reviewed for PASARR accuracy. This deficient practice has the potential to result in the facility not providing the services needed for residents who are identified in the screening process as needing additional care and services. The findings are: R #2:A. Record review of R #2's Face Sheet revealed the following: admission date of 09/02/25,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). B. Record review of R #2's PASARR Level 1 Screening, dated 09/02/25, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #3:C. Record review of R #3's Face Sheet revealed the following: admission date of 10/07/25,Diagnosis of major depressive disorder. D. Record review of R #3's PASARR Level 1 Screening, dated 10/06/25, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #5:E. Record review of R# 5's Face Sheet revealed the following: admission date of 09/26/23,Diagnosis of anxiety disorder (feelings of fear or apprehension). F. Record review of R #5's PASARR Level 1 Screening, dated 09/26/23, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #6:G. Record review of R #6's Face Sheet revealed the following: admission date of 02/04/26,Diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). H. Record review of R #6's PASARR Level 1 Screening, dated 02/04/26, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #7:I. Record review of R #7's Face Sheet revealed the following: admission date of 10/05/21,Diagnosis of major depressive disorder.J. Record review of R #7's PASARR Level 1 Screening, dated 02/04/26, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #8:K. Record review of R #8's Face Sheet revealed the following: admission date of 01/28/26,Diagnosis of depression. L. Record review of R #8's PASARR Level 1 Screening, dated 01/28/26, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #9: M. Record review of R #9's Face Sheet revealed the following: admission date of 02/02/24,Diagnosis of anxiety. N. Record review of R #9's PASARR Level 1 Screening, dated 01/28/26,</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #10:O. Record review of R #10's Face Sheet revealed the following: admission date of 02/02/24,Diagnosis of anxiety. P. Record review of R #10's PASARR Level 1 Screening, dated 09/03/24, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.R #11:Q. Record review of R #11's Face Sheet revealed the following: admission date of 08/06/24,Diagnosis of Major Depressive Disorder.R. Record review of R #11's PASARR Level 1 Screening, dated 08/06/24, revealed staff documented the resident did not have diagnoses such as schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), or disorders of mood, panic, anxiety, personality, psychotic, depression, and substance related.S. On 02/19/26 at 3:07 pm during an interview, the Social Services Director (SSD) stated the facility did not have a systematic process in place to review incoming PASARRs as part of the PASARR screening process for admissions. The SSD stated she was recently informed by the facility that reviewing resident PASARRs was the responsibility of her department. She stated PASARRs were not reviewed for accuracy. The SSD stated if residents are not properly screened, residents who require additional support and services may not receive the appropriate level of care. The SSD confirmed the PASARRs for R #2, R #3, R #5, R #6, R #7, R #8, R #9, R #10, and R #11 were not accurate, and she stated they should be.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on record review, observation, and interviews, the facility failed to maintain a safe environment for all residents in the 200-unit when staff failed to ensure the facility oxygen (O2) storage room was secured to prevent unauthorized access. This deficient practice has the potential to lead to residents experiencing avoidable accidents. The findings are: A. Record review of the facilities Oxygen Administration Policy, dated 06/2020, revealed the following:</p> <p>Oxygen cylinders are to be secured in a cylinder cart or bracket at all times,</p> <p>Oxygen stored in clean, dry locations.</p> <p>B. On 02/18/26 at 1:59 pm, observation of the facility's 200-unit oxygen room revealed the following:</p> <p>The oxygen storage room keypad door lock was without power and nonoperational. The keypad screen remained blank and did not activate when touched. Further observation revealed occupants in the area could open the oxygen storage room door without entering an access code.</p> <p>Oxygen cylinders (portable medical oxygen tanks) sat on the floor and were not stored in the designated oxygen cylinder rack.</p> <p>C. On 02/18/26 at 2:17 pm during an interview, the Central Supply Manger (CSM) stated all oxygen equipment, including portable oxygen tanks, must be stored in the proper storage areas for safety. The CSM stated if oxygen tanks are not properly stored, then it could create a hazard.</p> <p>D. On 02/19/26 at 1:00 PM during an interview, the Administrator stated the oxygen storage room should remain locked at all times when not in use. The Administrator stated she was not aware the keypad door lock was not functioning, and the door could be opened without entering a code. The Administrator stated she expected the oxygen storage room door to remain locked at all times.</p>