STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiesta Park Wellness & Rehabilitation	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident was free from neglect for 1 (R #131) of 1 (R #131) resident, when:The facility van driver failed to completely secure R #131's wheelchair in the van prior to transport.The facility van driver failed to contact emergency medical services (EMS) after the resident sustained a fall with injury during transport to an appointment. If the facility fails to properly secure residents in the transport van and contact EMS providers after a resident experiences a fall with injury, then residents are at risk for delayed treatment or worsening injury. The findings are:A. Record review of the facility's Vehicle Safety Program Policy, undated, revealed the policy directed authorized employees to operate company vehicles in a safe manner and ensure all occupants used seatbelts prior to moving the vehicle. The policy directed staff to ensure all wheelchairs were tied down securely before moving the vehicle. The policy directed staff to check for injuries and call Police/EMS, if needed in the event of an accident. B. Record review of R #131's face sheet revealed R #131 was admitted into the facility on [DATE] with the following diagnoses:Muscle weakness (reduction in the power exerted by muscles),Difficulty walking,Renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys cannot function properly). C. Record review of R #131's incident report, dated 03/02/26, revealed on 02/28/26 at approximately 1:00 PM during transport to a dialysis appointment, R #131's wheelchair tipped backward in the transport van when the van accelerated, but the staff was unsure if R #131 hit her head. Staff encouraged R #131 to go to the emergency room (ER), but she declined. R #131 later agreed to go to the ER and returned to the facility without any new diagnoses. On 03/01/26, R #131 developed bruising to her right foot and stated it was from the fall on 02/28/26. D. Record review of the facility's five-day follow-up report (a written report submitted to the State Agency within five working days following an alleged violation or incident, and it details the investigation findings and actions taken), dated 03/09/26, revealed the following:The facility van driver stated he secured the back straps to R #131's wheelchair, and he thought he secured the front straps. He went back inside the facility to give the receptionist a receipt. When he returned to the van, he drove off with R #131, and he did not realize he forgot to secure the front straps of R #131's wheelchair. Most of the transport was uneventful. As they neared the dialysis clinic, the driver stopped at a stop light. When the light turned green, the driver began to accelerate, and R #131 rolled backwards in her wheelchair. The facility van driver stated he pulled over as soon as possible. Once the van was pulled over, the driver assessed R #131. The facility van driver determined R #131 did not have any injuries and moved her. The facility van driver stated he was a nurse technician [medical care provider who give basic medical care to patients under the supervision of a Registered Nurse]. He secured all R #131's wheelchair straps and proceeded to take R #131 to her dialysis appointment. Once at dialysis, R #131 became upset, and the facility van driver reported the incident to his Supervisor.The facility van driver's Supervisor stated they viewed the van video, and it took the facility van driver approximately 30 seconds to pull over after R #131's wheelchair fell backwards. The Supervisor stated the facility expectation was the facility van driver should have secured all four of R #131's wheelchair straps (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	prior to transport, and the van driver should have called 911 immediately after R #131 fell backwards.R #131 stated the facility van driver locked in the back wheels of her wheelchair, but he did not secure the front wheels prior to transport. The resident stated she experienced pain to her neck and shoulders after she hit her head when the van accelerated. R #131 stated she told the van driver to call an ambulance, but he did not take her. She told the van driver to not move her, but he did anyway. R #131 stated she told the van driver to call for an ambulance multiple times, but he did not. She stated the van driver only mentioned his anxiety. R #131 stated she was scared and asked the dialysis staff to send her to the hospital. R #131 stated she experienced whiplash (neck injury caused by the head suddenly snapping forward and backward. It often causes neck pain and stiffness) and a bruised foot.During the investigation, the facility van driver was suspended, and R #131 was diagnosed with a broken toe.In conclusion, R #131 experienced a fall in the facility van after staff did not properly secure the resident, which caused her to experience whiplash and a broken toe. The facility van driver was terminated, but the facility did not believe abuse or neglect occurred. E. On 04/16/26 at 9:39 AM, during an interview, R #131 stated the facility van driver did not secure the front of her wheelchair prior to transport. She stated her wheelchair tipped backwards, and she fell to the floor of the van. R #131 stated she experienced immediate pain in her neck and back. R #131 stated she told the driver multiple times to call an ambulance, but the facility van driver did not call 911. R #131 stated she remained on the floor of the van for approximately five to seven minutes before the driver attempted to lift her. R #131 stated the driver continued the transport to the dialysis center, and he did not seek emergency medical care for her. R #131 stated dialysis staff later arranged an ambulance transport to the hospital. The resident stated she rated her pain at the time of the incident as a 10 out of 10 (a pain level of 10 out of 10 means the worst possible pain) and continued to experience pain in her neck, back, and foot. The resident stated the dialysis center monitored R #131 and then called 911 for transport to the hospital. The resident stated she was still in pain after she finished her treatment. F. On 04/16/26 at 10:38 AM, during an interview, the Administrator stated the facility van driver failed to properly secure the resident in the wheelchair. The Administrator stated the driver should have double-checked the restraints before leaving the facility. The Administrator stated staff did not properly secure R #131 during transport. G. On 04/20/26 at 2:22 PM, during an interview, the Director of Nursing (DON) stated they determined the facility van driver failed to secure the resident's wheelchair during transport, and the resident's wheelchair tipped over. The DON stated R #131 sustained a fractured fifth metatarsal (the long bone connected to the little toe of the foot). H. On 04/30/26 at 5:14 PM, during an interview, the facility van driver stated R #131 urged him to leave the facility quickly because he was running late for her appointment. He stated he secured the resident in the vehicle, departed for dialysis, and became distracted. The facility van driver stated approximately five minutes before arriving at dialysis, while driving uphill on a slight incline and accelerating, the resident's wheelchair tipped backward, and the resident fell backward. The driver stated he pulled over, assessed the resident, and noted she remained conscious and responsive. He stated the resident requested to continue to dialysis rather than call 911. The driver stated he transported the resident to the dialysis clinic, and he informed staff of the incident. The facility van driver stated facility staff later advised him that he should have called emergency medical services for the resident. The driver stated the resident did not request an ambulance.