

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/22/2026
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)		
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 abuse for 1 (R #2) of 1 (R #2) resident, when a facility Certified Nursing Assistant (CNA) engaged in unwanted physical contact with the resident and ate food from the resident's meal tray. This deficient practice resulted in R #2 experiencing fear, anxiety, tearfulness, sleep disturbance, emotional distress, and concern regarding retaliation. The findings are: A. Record review of R #2's Minimum Data Set (MDS; a standardized assessment used to evaluate a resident's clinical status and care needs) discharge assessment, dated 06/14/26, revealed: R #2 was admitted to the facility on [DATE] with the diagnoses of a displaced fracture of the lower end of the left femur (the large bone extending from the hip to the knee), impaired mobility, and weakness. R #2 had a Brief Interview for Mental Status (BIMS; a standardized cognitive screening assessment) score of 15, indicating the resident was cognitively intact. R #2 utilized a wheelchair for mobility. R #2 required assistance with transfers. B. Record review of R #2's nursing progress notes, dated 06/05/26, revealed R #2 appeared very concerned. The resident reported CNA #5 entered her room after dinner and appeared to be unbalanced, leaning, hovering over her, and moving side to side. R #2 reported CNA #5 touched her shoulder, rubbed it, and moved his hand down her arm. She stated she felt uncomfortable and scared during the interaction. R #2 stated CNA #5 grabbed her meal tray, took a bite from her hamburger, and left the room. R #2 stated she did not want CNA #5 to care for her anymore. R #2 stated CNA #5 smelled of alcohol and marijuana. C. Record review of R #2's nursing progress notes, dated 06/10/26, revealed R #2 approached the nursing station and requested to speak with the Director of Nursing (DON). R #2 was tearful and stated she did not sleep well since the incident involving CNA #5. The facility offered R #2 a referral to the facility's psychological provider and notified the DON. D. Record review of R #2's Patient Health Questionnaire (PHQ-9; a nine-item self-administered tool used to screen, assess, and monitor the severity of depression in adults), dated 06/10/26, revealed R #2 reported feeling down, depressed, or hopeless; difficulty falling asleep, staying asleep, or sleeping too much; and difficulty concentrating on things, such as reading the newspaper or watching television. E. On 06/15/26 at 1:09 PM, during an interview, R #2 stated CNA #5 entered her room on 06/05/26 during the evening shift and appeared unsteady, stumbled, and was not speaking normally. R #2 stated CNA #5 approached her meal tray, asked if she was finished with her hamburger, picked it up, took a large bite, and placed it back on her meal tray. R #2 stated CNA #5 began rubbing her arm and back in a sexual manner. She stated she pulled away from him quickly. She stated she felt violated, stunned, terrible, and trapped in her room while he was touching her. R #2 stated she wanted to run and get away, but she could not because she used a wheelchair. F. On 06/17/26 at 8:54 AM, during an interview, Licensed Practical Nurse (LPN) #9 stated R #2 reported CNA #5 acted strangely, swaying, and appeared unable to stand upright. LPN #9 stated R #2 reported CNA #5 took a bite from her hamburger and ran his hand down her arm. LPN #9 stated R #2 reported the CNA's behavior made her uncomfortable. LPN #9 stated she immediately notified Assistant Director of Nursing (ADON) #1. She stated another CNA was assigned to remain with R #2 while staff located CNA #5 and removed him (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/22/2026
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)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	from resident care duties. LPN #9 stated R #2 reported the contact made her feel uncomfortable and unsafe in the facility. G. On 06/17/26 at 10:00 AM, during an interview, ADON #1 stated R #2 initially appeared hesitant to discuss the incident because she was concerned about retaliation. ADON #1 stated R #2 believed CNA #5 was under the influence of an unknown substance and was not acting appropriately. He stated R #2 told him CNA #5 ate part of her hamburger and touched her arm in a sexual manner. ADON #1 stated R#2 was anxious and worried during their conversation. ADON #1 stated the facility staff searched the facility for approximately one hour before locating CNA #5 inside a locked restroom at the front of the building. He stated CNA #5 lay on the floor, unresponsive, snoring, with vomit around his mouth and on the floor. ADON #1 stated the facility called emergency medical services and law enforcement. ADON #1 stated he detected the odor of alcohol on CNA #5, and the CNA #5 admitted later to ingesting an unknown substance. H. On 06/17/26 at 2:00 PM, during an interview, the Administrator stated he was aware of the situation that occurred on 06/05/26 between R #2 and CNA #5. He stated it was his expectation the facility staff would not give any resident an unwanted touch or eat any portion of a resident's food.		

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 06/22/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to submit the required incident summary report for multiple days to the State Agency (SA) for 1 (R #1) of 1 (R #1) resident. If the facility does not submit the incident summary to the State Agency without delay, then the State Agency cannot appropriately triage (review) the allegation for further investigation. The findings are: A. Record review of the facility's abuse prevention program policy, revised 10/24/22, revealed the facility will promptly and thoroughly investigate all reports of abuse, mistreatment, neglect, injuries of unknown origin, or criminal acts. The policy states that staff must report allegations of abuse or neglect that do not result in serious bodily injury no later than 24 hours after forming the suspicion. B. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: Aspiration pneumonia (pneumonia caused by inhaling something other than air into the lungs). Respiratory failure (when the lungs can't supply enough oxygen or clear enough carbon dioxide to keep the body working). Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). Percutaneous endoscopic gastrostomy dependence (PEG; a type of g-tube). C. Record review of the facility incident report, dated 06/10/26 at 9:15 pm, revealed that on 06/06/26, a Nursing Student (NS) #1 provided R #1 with a regular breakfast tray despite physician orders for an NPO status. The incident report stated R #1 consumed portions of bacon and eggs before the error was identified and the tray was removed. R #1 became unresponsive and was discharged to the emergency room (ER) on 06/08/26. D. On 06/17/26 at 2:15 PM, during an interview, the Administrator stated he first became aware of the incident involving R #1 on 06/10/26 during the facility's morning meeting. He stated it was his expectation that R #1's incident should have been reported to the State Agency on 06/06/26, when it occurred but the incident report was not submitted until 06/10/26.		

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 06/22/2026
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)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide adequate oversight of nursing students in accordance with professional standards of practice for 1 (R #1) of 1 (R #1) resident reviewed, which resulted in a nursing student providing R #1 a meal tray despite R #1 having an active nothing by mouth (NPO) dietary order. If staff serve food to a resident with an NPO order, then the resident is at risk for aspiration, choking, respiratory distress, and other preventable adverse outcomes. ^ The findings are: A. Record review of the facility's nursing student educational agreement, dated 02/01/24, revealed the following: ^ The student responsibilities include following the facility's administrative policies, procedures, rules, and regulations, and providing services to the facility's patients under the direct supervision of a faculty member provided by the college or a facility provided preceptor. The facility's responsibilities include retaining ultimate responsibility for patient care and services, providing orientation for faculty and students, accepting a mutually agreed upon number of students enrolled in the program, and providing those students with a supervised clinical experience. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/06/26, revealed R #1 was admitted to the facility on [DATE] from the hospital. The MDS revealed R #1 had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 11, moderate cognitive impairment. The MDS revealed diagnoses including: Aspiration pneumonia (infection and inflammation of the lung caused by aspiration). Acute respiratory failure with hypoxia (when the lungs cannot adequately exchange oxygen and carbon dioxide, resulting in low levels of oxygen in the blood). Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). Percutaneous endoscopic gastrostomy (PEG; a type of G-tube) dependence. C. Record review of R #1's comprehensive care plan, initiated 06/03/26, revealed R #1 required tube feeding related to dysphagia. The care plan directed staff to discuss tube feeding with the resident and family, monitor nutritional and hydration status, and obtain Registered Dietitian (RD) evaluations and recommendations for tube feeding as needed. ^ D. Record review of R #1's physician orders revealed: An order, dated 06/03/26, for a nothing by mouth (NPO) diet. An order, dated 06/03/26, for continuous enteral feeding (the continuous administration of liquid nutrition through a feeding tube using a feeding pump). An order, dated 06/04/26, for continuous enteral feeding. E. Record review of R #1's nursing progress notes, dated 06/07/26, revealed the facility contacted the on-call provider regarding R #1, who was on an NPO diet and was mistakenly provided a breakfast tray. ^ Staff documented R #1 experienced chest congestion and had an oxygen saturation (the amount of oxygen in the blood) of 87 percent (%; normal range is 95 to 100%). ^ The resident's oxygen saturation improved with oxygen delivered at 2 liters per minute (LPM) through a nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). ^ The provider ordered a chest Xray and planned to reassess R #1. ^ F. Record review of R #1's Change in Condition (CIC) Situation, Background, Assessment, Recommendation evaluation (SBAR; a concise, standardized method for communicating important information about a patient or situation to ensure clarity and prompt action), dated 06/07/26, revealed R #1's oxygen saturation was 86% without supplemental oxygen and on room air. R #1 experienced abnormal lung sounds, including rales (crackles; abnormal, discontinuous lung sounds heard primarily during inhalation, often indicating fluid or mucus in the airways), rhonchi (low-pitched, continuous lung sounds caused by air moving through mucus or other obstructions in the larger airways, often resembling snoring or gurgling), and wheezing. ^ G. Record review of R #1's CIC-SBAR, dated 06/08/26, revealed R #1 was unresponsive and with congested lung sounds. The facility provider recommended R #1 be transferred to the emergency room. ^ H. Record review of R #1's hospital documentation, dated 06/08/26, revealed R #1 presented to the emergency room with shortness of breath and an increased need for oxygen use. R #1's chest x-ray revealed a concern for aspiration (the inhalation of foreign material, (continued on next page)		

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 06/22/2026
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)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	such as food, liquid, or gastric contents, into the airways or lungs) or multifocal pneumonia (lung infection characterized by multiple areas of inflammation or infection occurring in different regions or lobes of the lungs). ^ I. Record review of the facility incident report, dated 06/10/26, revealed a Nursing Student (NS) #1 provided R #1 with a regular breakfast tray on 06/06/26. The incident report stated R #1 consumed some bacon and eggs before staff identified the error and removed the meal tray. ^ J. On 06/16/26 at 11:00 AM, during an interview, the Certified Nursing Assistant (CNA) #1 stated NS #1 assisted with meal tray delivery on 06/06/26. CNA #1 stated he instructed NS #1 to deliver the meal tray to room [ROOM NUMBER] but NS #1 delivered the meal tray to room [ROOM NUMBER], where R #1 resided. CNA #1 stated he later observed R #1 with a breakfast tray and immediately notified the Licensed Practical Nurse (LPN) #1. The CNA #1 stated R #1 had consumed portions of bacon and eggs before the tray from the resident. ^ K. On 06/16/26 at 12:44 PM, during an interview, the Nursing Student Instructor (NSI) stated she supervised six first-level nursing students during their clinical rotation at the facility. The NSI stated the students received training through classroom instruction and simulation laboratories before participating in clinical rotations. She stated her role was to provide clinical instruction. The NSI stated she provided an orientation to the unit on the first day of clinicals and reviewed expectations, including meal tray delivery procedures. NSI stated nursing students were expected to verify each resident's identity, including the resident's name and room number, before delivering meal trays. The NSI stated students received education regarding diet orders, NPO status, and dietary restrictions. She stated residents' dietary restrictions, and NPO dietary orders were not routinely reviewed during the facility clinical orientation. The NSI stated students generally received information only for residents assigned to them. She stated if a student entered another resident's room, the student might not know that resident's dietary restrictions. The NSI stated she supervised six students, was present on the unit during meal tray delivery, and was not physically present with each student while meal trays were delivered. She stated students were working on both sides of the unit while she remained in a central location. The NSI stated she was informed of the incident involving R #1 immediately after it occurred. The NSI stated neither she nor her students received a facility-specific orientation before beginning the clinical rotation. ^ L. On 06/16/26 at 2:52 PM, during an interview, LPN #1 stated CNA #1 informed him of the incident involving R #1 shortly after the meal trays was delivered. The LPN #1 stated he immediately went to R #1's room and removed the meal tray from R #1. The LPN #1 stated he informed the resident he could not continue eating the food, because he was not allowed to eat food. ^ M. On 06/17/26 at 9:03 AM, during an interview, Nursing Student (NS) #1 stated she was assisting with meal tray delivery on 06/06/26. NS #1 stated Certified Nursing Assistant (CNA) #1 directed her to deliver a meal tray to a resident room. NS #1 stated she did not verify the meal tray ticket, the resident's identity, or the resident's diet order before delivering the meal. NS #1 stated she received education in nursing school regarding diet orders, NPO status, and verifying resident identification before providing care. NS #1 stated she was assisting the CNA with meal tray delivery and entered the room based on the CNA's directions. NS #1 stated she noticed the resident had a feeding tube but did not view it as a concern because some residents with feeding tubes are permitted oral intake. NS #1 stated she later learned R #1 had a NPO dietary order and should not have received food. NS #1 stated the clinical instructor was present on the unit but was not physically present with each student during meal tray delivery. NS #1 stated students worked under the supervision of the clinical instructor and could ask the instructor questions during the clinical rotation. NS #1 stated the facility did not provide an orientation regarding residents' diet orders, NPO status, code status, or facility-specific procedures before students participated in resident care. ^ N. On 06/17/26 at 12:54 PM, during an interview, the Medical Director (MD) stated residents who are fed food while on an NPO diet are at risk for choking and aspiration. The MD stated aspiration may occur without being directly observed, and symptoms may develop later. ^ O. On 06/17/26 at 1:30 PM, during an interview, the Director of Nursing (DON) stated NS #1 was not assigned to R #1 and would (continued on next page)		

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 06/22/2026
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)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not have known R #1 had a nothing by mouth (NPO) dietary order. The DON stated the Nursing Student Instructor (NSI) was responsible for supervising the nursing students during clinical rotations. The DON stated the resident had been discharged to the hospital. P. On 06/17/26 at 2:15 PM, during an interview, the Administrator (ADM) stated his expectation was for the instructor to supervise nursing students while in the facility. The Administrator stated he would not consider a CNA to be a qualified licensed professional, and CNA #1 should not have directed NS #1 to provide meal trays to residents. Based on record review and interviews, an Immediate Jeopardy (IJ) was identified. The facility ADM was notified in person on 06/17/26 at 6:42 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR). The POR was approved on 06/18/26 at 3:17 pm. Corrective action for affected resident: The resident involved in the incident was immediately assessed and monitored following identification of the meal delivery error on 06/06/26. The provider was notified, and appropriate clinical interventions were initiated on 06/06/26. The resident was transferred to the hospital on [DATE] when a change of condition was identified and remains under hospital care. An immediate audit was completed on 06/06/26 for all residents with provider orders for NPO status to verify dietary orders, meal service processes, and resident identifiers. No additional residents were identified as having received food contrary to provider orders. Resident Identification Procedures: On 06/13/26, nursing students and current licensed nursing staff received education regarding resident identification procedures. Follow-up reinforcement education was provided to licensed nursing staff on 06/17/26. Education included: Verifying resident identity prior to providing care, services, or meal delivery. Confirming that services and meal trays are provided to the intended resident. Verifying that the resident's name and room number match the information listed on the tray card prior to meal delivery. Seeking assistance from the nursing instructor or licensed nursing staff whenever questions arise regarding resident identification. Nursing Student Responsibilities and Supervision Expectations: On 06/13/26, nursing students and current licensed nursing staff received education regarding nursing student responsibilities and supervision expectations. Follow-up reinforcement education was provided to licensed nursing staff on 06/17/26. Education included: Nursing students are supervised by their assigned nursing instructor while participating in clinical experiences within the facility. Nursing students are expected to follow facility policies and procedures while providing resident services. Nursing students must communicate questions or concerns to their nursing instructor and supervising nurse. Nursing students may not perform resident care activities without supervision by their nursing instructor. Immediate Escalation and Notification Expectations: Beginning on 06/17/26, nursing students and current licensed nursing staff will receive education regarding immediate escalation and notification expectations prior to working the floor. Education included: Reporting concerns immediately to the nursing instructor and licensed nursing staff. Immediate nursing assessment when a resident receives services inconsistent with physician orders. Completion of facility incident reporting requirements. Notification of the attending provider, Director of Nursing, Administrator, resident representative, and other appropriate parties as indicated. Following facility reporting and notification procedures for significant clinical events. Oversight of Nursing Students: Effective 06/17/26, the facility implemented additional oversight measures for nursing students participating in clinical experiences. The nursing instructor will receive education regarding facility policies, resident identification procedures, incident reporting requirements, supervision expectations, and escalation processes. Education included the nursing instructor's responsibility to provide direct supervision of nursing students, review facility expectations with assigned students, communicate with facility nursing staff regarding student assignments, and immediately address concerns related to resident safety, prior to each new rotation. Nursing students will remain under the supervision of their assigned nursing instructor during clinical activities. Prior to each clinical experience, the nursing instructor will review facility expectations with assigned students. At the beginning of each clinical day, the nursing instructor will communicate with the charge nurse or designee regarding student (continued on next page)		

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 06/22/2026
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)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assignments and resident care activities. Facility nursing leadership or designee will conduct observational rounds during student clinical experiences to verify compliance with resident identification procedures and supervision expectations. Any concerns identified during observations will be addressed immediately through intervention and re-education as appropriate. The Director of Nursing or designee will monitor compliance with these processes to ensure ongoing resident safety. Implementation of the POR was verified onsite on 06/18/26, and the IJ was removed on 06/18/26 at 4:45 pm. The scope and severity were reduced from a J to a D. Implementation of the POR was verified by the following: On 06/18/26 at 3:00 PM, during an interview, the Assistant Director of Nursing (ADON) #2 stated the facility nursing management was recently educated regarding their responsibility for oversight and supervision of nursing students while in the facility. ADON #2 stated nursing students were required to be with facility staff or their nursing instructor while participating in clinical activities. ADON #2 stated nursing management would be more hands-on with the oversight of nursing students moving forward. ADON #2 stated the level of student participation depended on the student's clinical level, and the nursing students currently attending the facility were to observe and learn unless otherwise directed by facility management. ADON #2 stated nursing students would not be permitted to pass meal trays. ADON #2 stated staff received education regarding meal tray delivery procedures and the requirement that nursing students were not to participate in tray pass activities. On 06/18/26 at 3:18 PM, during an interview, LPN #7 stated the facility staff were expected to verify the correct resident, correct room, correct diet, and resident allergies before delivering a meal tray. LPN #7 stated this verification process applied to both room trays and meals served in the dining room. LPN #7 stated staff recently received education on meal tray verification procedures. LPN #7 stated if a resident received the wrong diet, then staff must immediately remove the tray, determine whether the resident consumed any portion of the meal, notify nursing management and the physician, and follow all physician orders. LPN #7 stated staff would initiate a CIC following such an event. LPN #7 stated if staff observed a nursing student performing activities outside the facility policy, then staff must immediately stop the activity and intervene. On 06/18/26 at 3:20 PM, during an interview, ADON #3 stated LPNs serving as nursing supervisors were responsible for the oversight of the building and ensuring staff followed the facility policies and procedures. ADON #3 stated Nursing Supervisors received education regarding the oversight and supervision of nursing students. ADON #3 stated the same expectations applied to nursing instructors supervising the nursing students while in the facility. ADON #3 stated nursing students were expected to observe and learn while in the facility and were not expected to independently perform tasks. ADON #3 stated the facility nursing management now participated in the oversight of nursing students throughout the building. ADON #3 stated the facility nursing management observed the nursing students during meal service and monitored student activities during all meals. On 06/18/26 at 3:25 PM, during an interview, LPN #6 stated staff received education regarding meal tray delivery procedures. LPN #6 stated staff were educated on the processes to verify the correct resident, correct diet, and compare the meal tray ticket to the resident before delivering a meal tray. LPN #6 stated staff should open the meal trays and verify if the contents match the diet order identified on the meal ticket. LPN #6 stated staff must follow this verification process for all meal trays, including trays delivered to resident rooms and meals served in the dining room. LPN #6 stated if a resident received an incorrect diet, then staff must immediately notify nursing management, complete an incident report, monitor the resident for changes in condition, and follow all physician orders and recommendations. LPN #6 stated nursing students were not permitted to provide resident care independently. LPN #6 stated if staff observe a nursing student performing tasks outside the scope of their permitted role, then staff must stop the activity immediately, educate the student, and notify the nursing instructor. On 06/18/26 at 3:27 PM, during an interview, LPN #8 stated staff received retraining on meal tray delivery procedures. LPN #8 stated staff were instructed to verify that the dietary ticket matches the food on the tray and to ensure the (continued on next page)		

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 06/22/2026
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)		
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	correct meal was delivered to the correct resident and room. LPN #8 stated the same verification process applied to residents receiving meals in their rooms and those dining in the dining room. LPN #8 stated if a resident received an incorrect diet, then staff must immediately notify nursing management and the provider. Staff must assess the residents to ensure the residents were not experiencing negative effects. LPN #8 stated staff would initiate a CIC if the residents experienced any negative effects from the incident. LPN #8 stated the nursing students were generally present to observe and learn but did not independently provide resident care. LPN #8 stated the nursing student instructors made rounds throughout the facility and checked on students during clinical activities. LPN #8 stated nursing students typically observed residents and completed assigned learning activities, but they were not expected to independently provide care or pass meal trays. On 06/18/26 at 3:39 PM, during an interview, LPN #1 stated he worked at the facility for approximately four years and served in his current position for approximately one year. LPN #1 stated he received education from the DON and ADONs regarding nursing student supervision. LPN #1 stated nursing students were not permitted to perform tasks independently and the nursing facility was expected to provide oversight while students were in the facility. LPN #1 stated the nursing students were generally expected to observe, shadow staff, and learn through observation. LPN #1 stated he recently received additional education that nursing students were not to perform tasks independently and should seek clarification from nursing management when questions arose. The facility staff were expected to notify nursing management when an incident occurred. On 06/18/26 at 3:46 PM, during an interview, CNA #1 stated staff were expected to verify meal trays to ensure residents received the correct meals and diets. CNA #1 stated if he observed a resident receiving the wrong diet, then he would immediately notify the nurse and report the concern. CNA #1 stated the nursing students were generally present to observe and learn and were not expected to provide resident care independently. On 06/18/26 at 3:50 PM, during an interview, CNA #3 stated she worked at the facility since October 2025. The CNA #3 stated the facility staff were expected to verify meal trays and meal tickets before delivering meals to residents. CNA #3 stated the facility staff verified the resident's diet order and identity and ensured the resident was authorized to receive the meal. CNA #3 stated the meal tray verification process applied throughout the facility, including resident rooms and the dining room. CNA #3 stated the nursing students were generally present to observe and learn and did not assist with meal service. CNA #3 stated she did not allow nursing students to pass meal trays because they may not be familiar with residents or their diet requirements. CNA #3 stated the nursing instructors directed students to observe and not to perform tasks independently. On 06/18/26 at 4:06 PM, during an interview, CNA #4 stated staff assisted with meal service by preparing trays, filling beverages, and ensuring condiments were provided as appropriate. CNA #4 stated the facility staff were expected to verify the correct resident received the correct meal tray and diet prior to meal service. CNA #4 stated if staff identified a resident receiving the wrong tray, then they should remove the tray immediately. CNA #4 stated the facility staff were expected to notify the nurse when a resident received an incorrect meal tray. CNA #4 stated the nursing students followed the direction of their nursing instructor and were present to observe facility operations.		