

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 04/20/2026
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the outdoor trash dumpster was covered to minimize odors and prevent pests or rodents. If staff fail to keep outdoor trash bins closed, the environment may become unsanitary, increasing the risk of pest infestation and disease transmission to residents. The finding are: A. On 04/14/26 at 2:14 PM, during an observation, an outside trash dumpster had its' lid left open, exposing waste material to the environment. B. On 04/20/26 at 9:47 AM, during an observation, an outside trash dumpster was unattended and had its' lid left open, making waste material accessible to the environment. C. On 04/20/26 at 9:50 AM, during an interview, the Dietary Manager (DM) stated the outside dumpster should remain closed when not in use. He stated leaving the dumpster open could attract pests.		

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to properly complete consent forms for 5 (R #3, R #12, R #13, R #74, and R #129) of 5 (R #3, R #12, R #13, R #74, and R #129) residents, when: Vaccination consent forms were not signed by residents or resident representatives for R #12, R #74, and R #129. Psychotropic medication (medication used to treat mental health conditions) consent forms were not signed by residents or resident representatives for R #3 and R #13. This deficient practice is likely to result in residents and/or their representatives not being consulted and informed of the risks and benefits of medications and treatments being provided to them. The findings are: Vaccination Consents: R #12: A. Record review of R #12's face sheet revealed R #12 was admitted into the facility on [DATE]. B. Record review of R #12's vaccination consent forms, undated, revealed the form was incomplete and without information present in the signature, date, and time sections indicating vaccination consent was not obtained for R #12. Further review revealed the provider notification of vaccination refusal section was also incomplete. R #74: C. Record review of R #74's face sheet revealed R #74 was admitted into the facility on [DATE]. D. Record review of R #74's vaccination consent forms, undated, revealed the form was incomplete and without information present in the signature, date, and time sections indicating vaccination consent was not obtained for R #74. Further review revealed the provider notification of vaccination refusal section was also incomplete. R #129: E. Record review of R #129's face sheet revealed R #129 was admitted into the facility on [DATE]. F. Record review of R #129's vaccination consent forms, undated, revealed the form was incomplete and without information present in the signature, date, and time sections indicating vaccination consent was not obtained for R #129. Further review revealed the provider notification of vaccination refusal section was also incomplete. G. On 04/16/26 at 2:05 PM, during an interview, the Director of Nursing (DON) stated the vaccination consent forms were mostly obtained verbally by the facility nursing staff, but the resident or representative name should be typed in the box if not signed in person. The DON stated the consent forms for R #12, #74, and #129 were incomplete and should have been completed. H. On 04/17/26 at 1:10 PM, during an interview, the Assistant Director of Nursing (ADON) and Infection Preventionist (IP), stated the signature line of the vaccination consent form must be completed for the consent form to be considered valid. Psychotropic Consents: (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #3: I. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE], with an initial admission date of 11/03/22. J. Record review of R #3's physician orders, dated 10/23/25, revealed the following medication orders: TraZoDone HCl (antidepressant) Oral Tablet 50 mg (milligrams): Give one tablet by mouth one time a day at bedtime for depression. Sertraline HCl (antidepressant and antianxiety) Oral Tablet: Give 50 mg by mouth one time a day for Depression/Anxiety. K. Record review of R #3's psychotropic medication consents, dated 10/27/26, revealed documentation indicated consent was obtained in person/written; however, the consent form lacked the signature of the resident or their Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) for the following medications: Sertraline Trazadone R #13: L. Record review of R #13 face sheet revealed he was admitted to the facility on [DATE] with the following diagnosis: Depression M. Record review of R #13's psychotropic medication consents, dated 03/23/26, revealed the following: Bupropion (antidepressant medication): Documentation indicated consent was obtained in person/written; however, the consent form lacked the signature of the resident or their POA. N. Record review of R #13's physician orders, dated 03/23/26, revealed the following: Bupropion: Oral Tablet Extended Release 12 Hour 100 mg to be administered by mouth. O. On 04/16/26 at 2:05 PM, during an interview, the DON stated the consent forms are mostly obtained verbally, but the resident or representative name should be typed in the box if not signed in person. The DON stated the consent forms for R #3 and #13 were incomplete and should have been completed. P. On 04/17/26 at 1:10 PM, during an interview, the ADON stated the consent form did not require a handwritten signature and a typed name was acceptable. She the signature line of the psychotropic medication consent form must be completed for the consent form to be considered valid.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was accurate for 2 (R #4 and R #7) of 2 (R #4 and R #7) residents reviewed for MDS accuracy, when: R #4's MDS indicated she had clear speech when she was non-verbal (a person that does not speak). The facility staff did not complete R #7's mood assessment section of the MDS. This deficient practice is likely to result in a failure to provide adequate care and treatment of residents' needs. The findings are: R #4: A. Record review of R #4's face sheet revealed an admission date of 11/21/2023 and the following diagnoses: Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), Cognitive impairment (a decline in cognitive function), Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), Muscle wasting and atrophy (a decrease in muscle mass and strength). B. Record review of R #4's Comprehensive MDS, dated [DATE], revealed R #4 has clear speech. C. Record review of R #4's Quarterly MDS, dated [DATE], revealed R #4 has clear speech. D. Record review of R #4's nursing progress notes revealed the following: Dated 01/21/26, R #4 is non-verbal and unable to answer questions as per her baseline (the starting point of an individual's physical, mental, and emotional health, used as a reference to track changes, monitor progress, and guide preventive or therapeutic care). Dated 02/13/26, R #4 is non-verbal. Dated 04/15/26 R #4 is non-verbal and unable to answer questions as per her baseline. E. On 04/14/26 at 9:37 AM, during an interview, Certified Nursing Assistant (CNA) #4 stated R #4 is non-verbal. F. On 04/14/26 at 9:50 AM, during an interview, Licensed Practical Nurse (LPN) #4 stated R #4 is non-verbal. G. On 04/20/26 at 9:21 AM, during an interview, the MDS Coordinator stated R #4's MDS dated [DATE] and 02/25/2026 were documented incorrectly. She stated R #4 was non-verbal, but each MDS indicated R #34 had clear speech. The MDS Coordinator stated it is her expectation that each MDS should be completed and accurate. She stated if the MDS is not completed accurately, miscommunication in caring for the resident can occur. R #7: (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #7's face sheet revealed R #7 was originally admitted into the facility on [DATE]. I. Record review of R #7's re-entry MDS, dated [DATE], revealed R #7's mood and mood interview was not completed by the facility staff. J. On 04/20/26 at 10:30 AM, during an interview, the MDS Coordinator stated R #7 was not assessed for mood on the MDS dated [DATE] and should have been. She stated it was the responsibility of Social Services Department to complete the Mood assessment, and it is the responsibility of the MDS Department to ensure R #7's MDS was completed. K. On 04/20/26 at 2:24 PM, during an interview, the Director of Nursing (DON) stated the Social Services Department is responsible for completing mood assessments. The DON stated R #7's MDS mood assessment, dated 03/20/26, should have been completed but it was not. L. On 04/20/26 at 3:15 PM, during an interview, the Administrator (ADM) stated R #7's MDS mood assessment, dated 03/20/26, should have been completed.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review and interviews, the facility failed to develop and implement an adequate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 1 (R #11) of 1 (R #11) residents reviewed for baseline care plans, when: R #11's baseline care plan was incomplete and inaccurate due to the baseline care plan failing to include foley catheter (a thin, sterile tube inserted into the bladder to drain urine) use with interventions. If the facility fails to develop and implement an adequate baseline care plan within 48 hours of admission for residents, then staff may lack necessary guidance to provide appropriate care which could lead to an adverse event (undesirable experience, preventable or non-preventable, that causes harm to a resident due to medical care or lack of medical care). The findings are: A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE] with the following diagnoses: Urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra), Retention of urine (a condition that occurs when a person is unable to empty their bladder, either partially or completely). B. Record review of R #11's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 03/28/26, revealed R #11 was admitted with a foley catheter. C. Record review of R #11's March 2026 treatment administration record (TAR) revealed the following: Foley catheter care every shift. R #11 required the use of a Foley catheter due to chronic urinary tract infections. D. Record review R #11's baseline care plan, dated 03/26/26, revealed foley catheter use was not included in R #11's baseline care plan. E. On 04/17/26 at 11:00 am, during an interview, Certified Nurse Aide (CNA) #8 stated R #11 used a foley catheter when he was admitted into the facility. F. On 04/20/26 at 2:22 pm, during an interview, the Director of Nursing (DON) stated R #11 had a foley catheter in place during the resident's stay, but R #11's foley catheter use was not included in his baseline care plan and should have been.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure the proper storage and security of medications located in the medication carts, when: The 200-unit narcotic (controlled medication used for the management of pain) box located in a medication cart was left unlocked. Medications were pre-poured (the practice of preparing and pouring medications in advance of their scheduled administration time, which carries significant risks) prior to administration and left in the medication cart located in the 400-unit. A medication tablet was left out of the packaging and on the floor in the 200-unit. This deficient practice is likely to increase the risk of unauthorized access to medications, medication diversion, contamination, and administration of medications to the wrong resident. The findings are: Medication Cart Narcotic Box: A. On 04/15/26 at 1:46 PM, during an observation, the narcotic box located in one of the two medication carts in the 200-unit behind the nurse's station was found to be unlocked and could be easily opened, allowing access to the narcotic medications stored inside. B. On 04/15/26 at 1:47 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated the narcotic box located in the medication carts should always be locked. She stated the narcotic box is not locking properly and that was reported to the pharmacy on 04/13/26. She stated if the narcotic box is not properly locked, anyone could easily open and take medications which do not belong to them. She stated there could be several potential adverse outcomes for whoever consumed the medications. C. On 04/15/26 at 1:56 PM, during an interview, the Director of Nursing (DON) stated the narcotic box should be secured behind two locks at all times when not in use. She stated she was informed of the narcotic box not locking on 04/14/26. She stated the narcotics should have been moved to another medication cart because they were unable to be stored securely in their current location. Pre-Poured Medications: D. On 04/15/26 at 8:00 AM, during an observation, Certified Medication Aide (CMA) #1 was observed removing three lidocaine patches (a local anesthetic that prevents pain by blocking the signals at the nerve endings in the skin) from the packaging, dating and initialing each lidocaine patch, and then placed each prepared lidocaine patch in the medication cart for future use. E. On 04/16/26 at 7:59 AM, during an observation, CMA #2 was observed preparing medications for a resident, and then realized he needed to obtain a nutritional shake from the refrigerator. CMA #2 placed the prepared medication in the top drawer of the medication cart, locked the cart, and then left the cart to obtain the nutritional shake. F. On 04/15/26 at 8:16 AM, during an interview, CMA #1 stated medications should not be pre-poured or prepared in advanced prior to medication administration. G. On 04/16/26 at 8:01 AM, during an interview, CMA #2 stated pre-poured medications should not be placed in medication carts. If they have prepared medications and need to obtain another or other (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplies, they are to give the medications they have prepared to the resident and then obtain the missing item. H. On 04/20/26 at 2:25 PM, during an interview, the Director of Nursing (DON) stated it is her expectation medications are not pre-poured, and if a staff member needs to step away from cart to obtain other medications, the medications should be taken with the staff member and not placed in the medication cart while the staff member is away. Medication on the Floor: I. On 04/13/26 at 1:01 PM, during an observation, a small round peach-colored oral tablet with the imprint H1 was lying on the floor in the 200-unit between rooms #215 and #216. The medication was on the ground next to the wall by the baseboard, and facility staff was not present. The medication cart was observed down the hall near the nursing station. J. On 04/13/26 at 1:10 PM, during an interview, the Assistant Director of Nursing (ADON) stated she was unsure what type of medication was left on the floor, but the medication tablet should not have been left on the floor. K. On 04/13/26 at 1:31 PM, during an interview, the DON stated she did not know how the medication tablet was left on the floor. She stated she was unsure what the medication was for and initially thought it may have been for blood pressure; however, she could not confirm. She stated the medication tablet should not have been left on the floor and that it was her expectation that medications remain secured at all times.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plan interventions were implemented for 1 (R #5) of 1 (R #5) resident reviewed for falls. If the facility does not ensure care plan interventions for falls are implemented, then residents are at risk for continued falls and potential injury. The findings are: A. Record review of R #5's face sheet revealed R #5 was originally admitted into the facility on [DATE]. B. Record review of R #5's nursing progress notes revealed the following: R #5 had a Change in Condition (CIC; a comprehensive re-evaluation of physical, mental, or psychosocial status that occurs when baseline functioning is altered or indicates a new, ongoing risk) assessment completed for a fall on 04/07/26. R #5 had a CIC assessment completed for a fall on 04/09/26. C. Record review of R #5's Care Plan, dated 04/10/26, revealed the following: R #5 was at risk for falls related to generalized weakness and impaired mobility. Dated 04/07/26, new fall interventions were added to R #5's care plan stating R #5 was re-educated to be patient and wait for staff to assist her on and off the toilet, and she was supplied with non-slip socks for her feet. Dated 04/10/26, new fall interventions were added to R #5's care plan stating R #5 was educated to call for assistance when transferring, and while in her orthopedic boot (a removable medical device used to stabilize, protect, and support the foot and ankle during recovery from injuries or surgery). D. On 04/16/26 at 2:12 pm, during an interview, Certified Nursing Assistant (CNA) #3 stated she had worked with R #5 and was aware of R #5's falls. CNA #3 stated R #5 did not have any fall precautions (interventions designed to reduce injury risk by addressing resident-specific factors and environmental hazards) in place to prevent her from falling. E. On 04/16/26 at 3:14 pm, during an interview, Licensed Practical Nurse (LPN) #3 stated R #5 did not have any fall precautions and reported there were not any new interventions implemented following R #5's prior falls on 04/07/26 and 04/09/26. LPN #3 stated management (the Administrator, Director of Nursing, and nursing supervisors) are responsible for updating the resident care plans, and informing the nursing staff of new interventions added to the care plan to be implemented. LPN #3 stated the facility nursing staff relies on management to communicate any changes made to a resident's care plan. F. On 04/20/26 at 3:00 pm, during an interview, the Director of Nursing (DON) stated R #5's fall interventions included the use of non-skid footwear, the use of call light assistance, and instruction for R #5 to wait for staff before transferring. The DON stated that after each fall, she added new fall interventions to R #5's care plan. The DON stated she expects the facility nursing staff that are caring for R #5 to be aware of each fall intervention and implement each intervention to prevent R #5 from experiencing falls.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record review, and interviews, the facility failed to ensure staff revised the care plan for 1 (R #74) of 1 (R #74) resident reviewed, when: Facility staff failed to update R #74's plan of care to include R #74's use of a Hoyer lift (equipment used to safely transfer residents with limited mobility) for transfers. This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated. ^ The findings are: A. Record review of R #74's face sheet revealed admission date of 12/30/2025 with the following diagnoses: Spinal stenosis (narrowing of the space surrounding the spinal cord causing pressure and pain), Muscle weakness (reduction in the power exerted by muscles), Need for assistance with personal care and activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). B. Record review of R #74's care plan, dated 12/30/2025, revealed R #74's Hoyer lift use was not included in her care plan. C. On 04/14/2026 at 10:40 AM, during an observation, Certified Nursing Assistants (CNAs) #5 and #6 were observed using a Hoyer lift to transfer R #74 from her bed to her wheelchair. D. On 04/14/2026 at 10:49 AM, during an interview, R #74 stated the facility nursing staff use a Hoyer lift to transfer her in and out of bed. R #74 stated following a recent infection, she became significantly weakened and required increased assistance, including the use of a Hoyer lift for transfers. E. On 04/16/2026 at 3:31 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated R #74 requires two-person assistance when transferring. LPN #3 stated the resident uses a Hoyer lift for transfers. F. On 04/17/2026 at 2:21 PM, during an interview, the Director of Nursing (DON) stated it is her expectation all residents who utilize a Hoyer lift are care planned accordingly to their care needs. The DON stated if a resident's care plan does not reflect the required care, resident care information can be miscommunicated. The DON stated R #74's use of a Hoyer lift for transfers should have been care planned but was not.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide quality care that meets professional standards for 1 (R #25) of 1 (R #25) resident reviewed, when staff failed to: Update R #25's physician orders to reflect a new dialysis (a medical treatment which filters waste and excess fluid from the blood) schedule. This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: A. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE] with the following diagnosis: End stage renal disease (ESRD; chronic irreversible kidney failure) B. Record review of R #25's active physician orders, dated 12/22/25, revealed R #25's dialysis is scheduled for Monday, Wednesday, and Friday at 6:00 am. C. Record review of R #25's care plan, dated 12/22/25, revealed R #25's days of dialysis treatment is Monday, Wednesday, and Friday at 6:00am. D. On 04/14/26 at 10:00 am, during an interview, R #25 stated he goes to Dialysis on Tuesday, Thursday, and Saturday at 11:45 am. E. On 04/20/26 at 2:22 pm, during an interview, the Director of Nursing (DON) stated R #25's dialysis schedule has changed, and R #25's physician orders and care plan should have been updated to reflect the new dialysis schedule.		

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 04/20/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain a safe and sanitary environment to prevent the transmission of infectious agents and communicable diseases for 1 (R #10) of 3 (R #10, #52, and #62) residents, when the facility: Failed to prevent a urinary catheter (a thin, flexible tube which drains urine from the bladder) bag and tubing from touching the floor. These deficient practices have the potential to expose staff and other residents to infectious diseases. The findings are: A. Record review of R #10's face sheet revealed R #10 was admitted into the facility on [DATE]. B. Record review of R #10's care plan, dated 04/13/26, revealed R #10 used a foley catheter (a thin, sterile tube inserted into the bladder to drain urine) due to Neurogenic bladder (a condition in which nerve damage or neurological disorders disrupt the normal communication between the brain, spinal cord, and bladder, leading to loss of bladder control). C. On 04/15/26 at 11:23 AM, during an observation, R #10 was observed sitting in her wheelchair while being pushed to activities by a facility staff member. R #10's urinary catheter bag was dragging on the floor as she was pushed in her wheelchair. D. On 04/20/26 at 8:22 AM, during an interview, Licensed Practical Nurse (LPN) #2 stated a resident's urinary catheter bag should be secured below the level of the bladder. She stated the urinary catheter bags should not be allowed to touch or drag on the ground, as it presents a risk of infection for the residents. E. On 04/20/26 at 2:24 PM, during an interview, the Director of Nursing (DON) stated her expectation is resident's urinary catheter bags are to be secured below the bladder and should not be dragging or laying on the floor. She stated there is a risk the bag could open and present the risk of infection to the residents.		