STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers for 1 (R #1) of 1 (R #1) residents reviewed for ADL care. This deficient practice is likely to negatively affect the dignity and health of the residents. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and discharged on [DATE]. B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) indicated R #1 was dependent on staff assistance for showers. C. Record review of the facility's shower logs revealed the record did not contain shower sheets for R #1 for the months of September and October, 2024. D. On 11/14/24 at 9:35 am, during an interview, R #1's daughter stated R #1 had a series of falls at home and ended up in the trauma intensive care for a couple weeks. She stated her father transferred to the facility on [DATE], and he was full assist with eating, drinking, and bathing. The daughter stated her mother was at the facility most of the time. She stated her mother would push the call light for staff, but they would not come to the room. The daughter stated the facility staff did not assist her father with oral care, and the staff told them the family was responsible to do it. The daughter stated her father wore the same soiled hospital gown for a week, and he looked unclean. She stated they brought clean clothes to the facility for R #1 and laid them out for staff to dress him. The daughter stated she and her mother begged the staff to shower her father, but he did not receive a shower during the six weeks he was at the facility. The daughter stated a staff member promised them R #1 would receive a shower before he was discharged , but he did not receive one. The daughter stated her father discharged from the facility on 10/17/24 and transferred to her sister's house where he passed away a few days later. E. On 12/09/24 at 12:27 p.m., during an interview with the Director of Nursing (DON), she stated the facility did not have any records to indicate that staff offered R #1 a shower or that R #1 received or refused a shower.

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