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	04/03/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain proper infection prevention practices, when staff did not assure: -Cats in the Memory Care Unit were not defecating (discharging feces [bodily waste discharged through the anus] from the body) in the resident's room. -Cats not having trimmed or nail covers. These deficient practices could likely result in the spread of infectious agents (viruses and bacteria) to the residents. The findings are: A. On 04/01/25 at 9:00 AM, during observation of the Memory Care Unit revealed the following: - The facility has two domestic feline cats. One cat was walking out of a resident's room, while the second cat was seen sleeping on a chair in the hallway. - The cat crate was next to the TV in the family room. - A litter box was behind the recliner chair in the family room. B. On 04/01/25 at 9:05 AM, during observation of the Memory Care Unit rooms revealed the following: - room [ROOM NUMBER]B: Dried cat feces was on the floor beside the bed. - room [ROOM NUMBER]B: Dried cat feces was on the resident's bedding. - room [ROOM NUMBER]B: Dried cat feces was on the floor beside the bed. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. On 04/01/25 at 11:20 AM, during an interview with Certified Nurse Aide (CNA) #1, she stated she was unsure who cleaned the cat litter boxes as she had only worked in the memory care unit for a few shifts. She mentioned if cat feces were in the rooms, she would pick it up with the red hazard bag and dispose of it. Then, she would ensure that she cleaned and sanitized the floor. If the cat urinated on the beds, she would get a red hazard bag and dispose of the sheets or blanket because she believed no one could get the urine smell out of the sheets. D. On 04/01/25 at 3:30 PM, during an interview, the Director of the Memory Care Unit (MCU) The director mentioned that R #2 had been scratched by one of the cats, which resulted in a change in her condition. She stated the facility had ordered a scratching post for the cats; while it has arrived, maintenance has not yet assembled it. The cats currently do not have nail covers, and the director was unsure when their nails were last trimmed. She stated she was unaware of the cats defecating on the floor or beds in the residents' rooms, but she would have the bedding changed. The director further indicated that the Activities staff is responsible for cleaning the cat litter box. E. On 04/02/25 at 9:35 AM, during an interview, the Director of Nursing (DON) stated the cats have had nail covers in the past, but she is unsure if they are on now. She said they have a new staff member who is comfortable trimming the cat's nails and putting the nail covers on the cats.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure the facility was free of accident hazards for 19 (R #1-19) of 19 (R #1-19) when the facility failed to ensure no sprinkler above the ground courtyard area could cause a trip hazard. This deficient practice could likely results in a resident falling, putting them at serious risk of adverse outcomes. The findings are: A. On 04/01/25 at 3:00 pm, during an observation of the memory care unit courtyard revealed an unnamed person was walking in the courtyard area of the memory care unit while walking toward the gate, walking away from the building to check to see if the gate was unlocked. The unnamed person tripped over a lawn sprinkler head that was sticking out of the ground approximately 6 inches. B. On 04/03/25 at 10:18 am, during an interview with the Administrator, she stated that if a lawn sprinkler in the courtyard is above ground measuring approximately 6 inches, it is not ideal, but she is unaware of any incidents that have occurred because of it. The Administrator stated that on the same outside courtyard where the gates are, the gates automatically open and release when the fire alarm goes off, so there is a way off the property, the lawn sprinkler head causing a potential hazard. C. On 04/03/25 at 10:58 am, during an interview with the Maintenance Director, he stated the memory care unit courtyard, the lawn sprinkler head had been frozen up and was supposed to recess back into the ground. It should not be above ground the way that it is now. He stated that he would put a cone on it and that the landscapers would be out today to fix it.

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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 interview, the facility failed to maintain proper infection prevention measures by having: - The oxygen cannula (a medical device that provides supplemental oxygen) on the ground. -Unbagged oxygen cannula wrapped around back wheelchair handle. Failure to adhere to an infection control program could likely spread infections and illness to all residents of the memory care unit. The findings are: A. On 04/01/25 at 9:05 AM, during observation of the Memory Care Unit rooms revealed the following: -room [ROOM NUMBER]A: An unused nasal cannula connected to an oxygen concentrator (a device that concentrates the oxygen from a gas supply) lay on the floor underneath a pair of shoes. While in the room, the cat walked across the nasal cannula. -room [ROOM NUMBER]A: An unused nasal cannula was on the floor next to the bed, connected to an oxygen concentrator. B. On 04/01/25 at 10:00 AM, during an observation of the dining/activities room, R #3 sat in her wheelchair and wrapped an unbagged oxygen cannula around her wheelchair handle. C. On 04/01/25 at 11:20 AM, during an interview with Certified Nurse Aide (CNA) #1, she stated the oxygen cannulas in rooms 106A and 107A should not have been on the floor. If the cannula were on the floor, staff picked them up, sanitized them with sanitation wipes, wrapped them up, and put them on the oxygen condensers. If we noticed the cannula was dirty, we would have gotten a new one and replaced it. D. On 04/01/25 at 1:46 PM, during an interview with Registered Nurse (RN) #1, she stated the oxygen cannula wrapped up on the back of the R #3 wheelchair was there because the resident was on as-needed (PRN) oxygen. RN #1 stated she was unsure if the oxygen cannula should have been in a bag or if it could have remained on the back of her chair while not in use. E. On 04/01/25 at 3:30 PM, during an interview, the Director of the Memory Care Unit (MCU) stated that nasal oxygen cannulas should not be left on the floor. If any cannulas are found on the floor, they must be disposed of, and a new one will be provided to the residents. If cannulas are stored on the backs of residents' chairs, they should be kept in a plastic bag. F. On 04/02/25 at 9:35 AM, during an interview, the Director of Nursing (DON) stated that if residents' oxygen cannulas are on the floor, staff are expected to throw the cannula away and get a new one. She said that if an unused oxygen cannula is on the back of a resident's wheelchair, it should be in a bag so it does not get dirty.