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	12/18/2025

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure call lights were accessible and within reach for residents at risk for falls and injury. This failure occurred for 3 (R #3, R #4, and R #5) of 3 (R #3, R #4, and R #5) reviewed and created the potential for accidents, delayed response to resident needs, and injury. The findings are:R # 3AA. Record review of the facility's Call Light Policy dated 07/15/25 revealed staff will ensure call lights are within reach of the patient and secured as needed.BB. Record review of R #3's facesheet revealed R #3 was admitted to the facility on [DATE] with diagnosis: Repeated falls, Difficulty in walking, Muscle waste (reduction in the power exerted by muscles) and atrophy (partial or complete wasting away of a part of the body), Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infraction affection right dominant side.CC. On 12/17/25 at 12:25 p.m., during an observation of R #3 lying in bed resting, a white call light with a coiled cord was lying on the floor next to the resident bed. The call light was partially extended beneath the bedside area; the call light was positioned on the floor near the bed frame and bedside table legs.DD. On 12/17/25 at 12:28 p.m., during an interview with Certified Nurse Aide (CNA) #1, she stated the call light should not be under the bed, she stated if the call light is not in reach of the resident the resident could reach over and fall on the ground and get hurt. R #4EE. Record review of R #4 facesheet revealed R #4 was admitted to the facility on [DATE] with diagnosis of: Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Insomnia, Muscle weakness, Lack of coordination.F. F. Record review of R # 4 Annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/30/25 with a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) of 12 (8-12 is moderately impaired).GG. On 12/17/25 at 12:32 p.m., during an observation of R #3 lying in bed asleep, the call light was lying on the floor, positioned under the bed frame in close proximity of the wheels and base of an oxygen concentrator.HH. On 12/17/25 at 12:42 p.m., during an interview with CNA #2, she stated the call light should not be under the foot of the bed, she stated the call light should be secured to the side of the pillow so the residents can reach the call light when they need help. She stated if the call light is on the floor the resident could attempt to get the call light and fall out of bed.R #5I. I. Record review of R #5's facesheet revealed he was admitted on [DATE] with diagnosis of: Seizures (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) Muscle spasm Contracture (a shortening of muscles around joints causing joint stiffness and immobility) left hand, hip, and kneeJ.J. Record review of R #5's MDS revealed he has a BIMS of 12.K K On 12/17/25 at 3:25 p.m., during an observation of R #5 lying in bed revealed the call light was laid on top of the air pump used to operate the resident specialty mattress at the foot of the bed.L L. On 12/17/25 at 3:46 p.m., during an interview with CNA #3, she stated the call light should not be laying at the foot of the bed, she stated the call light should be in reach of the resident. She stated if the call light is not in reach of the resident, then the resident could not call for help if he needs it. M. On 12/18/25 at 10:43 a.m., during an interview with Director of Nursing (DON), she stated all call lights should be clipped to the resident's beds so all residents could reach their call lights when they need assistance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, observation and interview, the facility failed to ensure medications were stored securely when a medication cart remained unlocked and unattended on the 500 Hall. This failure created the potential for unauthorized access to medications, including controlled substances, for 1 of 1 medication carts observed.The findings are:A. Record review of the facility's Medication Storage and Security Policy, revised January 2025, revealed the facility requires all medications to be kept secured at all times. The policy states medication carts must remain locked when not in the direct possession of licensed staff, and controlled substances must be stored in a separately locked, permanently affixed compartment. The policy further states staff must ensure medications are protected from unauthorized access by residents, visitors, or staff. B. On 12/18/25 at 8:06 a.m., observation of the 500 Hall revealed a medication cart positioned in the hallway with the drawers unlocked and the nursing computer left open with the medication administration record (MAR). No staff were present in the immediate area, and the cart remained unattended and accessible to residents walking through the hallway.C. On 12/18/25 at 8:08 a.m., during an interview, RN #1 stated she had just stepped away for a moment into a resident's room and stated she left the cart unlocked. RN #1 stated the cart contained narcotics stored inside the locked box, but the remaining drawers contained other resident medications. RN #1 stated, If the medication cart is left unlocked a resident could get into the cart and take medication that does not belong to them.D. On 12/18/25 at 1:32 p.m., during an interview with Director of Nursing (DON), stated it is her expectation all medications carts should remained locked at all times. She stated if the medication carts are not locked then a resident could go into the medication cart and take medication that does not belong to them.