

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Bear Canyon Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interviews, the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) regarding residents of the 600-nursing unit, where unauthorized people had ability to access it. If the resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors, and staff. The findings are: A. On 06/25/26 at 3:15 pm, during an observation of the 600 unit, an unattended bedside table was positioned in the hallway with a computer containing residents' protected health information, including names and room numbers, visible to anyone walking by. B. On 06/25/26 at 3:22 pm, during an interview, Registered Nurse (RN) #1 stated residents' PHI should not be left unattended, because unauthorized individuals could easily access the information. C. On 06/26/26 at 10:13 am, during an interview, the Director of Nursing (DON) stated the unattended computer left open in the 600 unit, with residents' medical records visible and accessible to anyone, should not have been left unattended. She stated her expectation is for nursing staff to understand the importance of safeguarding resident records.		

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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(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 - Some	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. Based on observation and interviews, the facility failed to provide a safe and homelike environment for all residents on the 600 unit by not maintaining the hallway, including preventing a chair and table from being placed against the handrail and staff storing personal belongings on the chair and table. If the facility fails to maintain a safe and homelike environment, then residents are likely to feel uncomfortable, and existing health issues could worsen. The findings are: A. On 06/25/26 at 3:15 pm, during an observation of the 600 unit, a bedside table with a drink cup, a plate of salad, and a chair with an open tote bag was positioned in the unit hallway in front of the handrail, without facility staff nearby. B. On 06/25/26 at 3:22 pm, during an interview, Registered Nurse (RN) #1 stated the facility staff should never leave items in the hallways, especially open drink containers, food items, purses, bags, or other personal belongings. She stated residents could pick up unattended items or trip on the bedside table and chairs. C. On 06/25/26 at 3:38 pm, during an interview, the Director of Nursing (DON) stated leaving a bedside table unattended with a laptop computer, a plate of food, a drink, and a personal tote bag on a chair was unacceptable. She stated her expectation is for nurses and certified nursing assistants (CNAs) to avoid leaving items in the unit hallways that are accessible to multiple residents. The DON stated leaving items unattended in the hallways is unsafe because residents could easily access the items on the table and inside the open tote bag.		