

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

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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 07/30/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to submit the required incident summary report and five-day follow-up investigation results to the State Agency for 1 (R #2) of 1 (R #2) resident reviewed for a fall with injury. If the facility does not submit the incident summary report and the summary of the facility's investigation to the State Agency within the required timeframe, the State Agency is unable to appropriately review the allegation for further investigation. The findings are: A. Record review of the facility's accidents and incidents policy, revised on 03/01/24, revealed the following: Facility staff are expected to report, review, and investigate all accidents and incidents involving a resident. The Administrator and/or Director of Nursing (DON) will verify state reporting occurred within required timeframes and by the appropriate reporting method. B. Record review of R #2's face sheet revealed an admission date of 08/20/23. C. Record review of R #2's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 04/28/26, revealed R #2 had the following diagnoses: Non-Alzheimer's dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). Muscle weakness (generalized). Repeated falls. D. Record review of R #2's nursing progress notes, dated 04/26/26, revealed R #2 experienced a fall at 3:00 pm due to an unsteady gait. R #2 struck his head and sustained a head laceration (a cut or tear in the skin) and was transferred to the hospital for evaluation. E. Record review of R #2's hospital Discharge summary, dated [DATE], revealed R #2 was diagnosed with a scalp hematoma (a collection of blood beneath the scalp caused by trauma) after the fall. F. On 07/30/26 at 4:05 pm, during an interview, the DON stated it was the facility's expectation to report any falls resulting in injury or a change in condition requiring transfer to the hospital to the State Agency. The DON stated R #2's fall on 04/26/26 should have been reported to the State Agency because R #2 sustained a head laceration and required transfer to the hospital for an evaluation. The DON stated failure to submit a report for a reportable event could prevent the State Agency from conducting the appropriate regulatory review or investigation to determine whether corrective actions were necessary to prevent similar occurrences. G. On 07/30/26 at 4:30 pm, during an interview, the Administrator (ADM) stated it was the facility's expectation to report incidents involving major injuries, abuse, neglect, or residents transferred to the hospital for evaluation after a serious incident to the State Agency. The ADM stated the facility's expectation was, When in doubt, report. The ADM stated R #2's fall on 04/26/26 should have been reported because the resident was transferred to the hospital following the fall. The ADM stated he did not find documentation indicating R #2's fall on 04/26/26 had been reported to the State Agency. The ADM stated failure to submit a report for a reportable event could prevent the State Agency from reviewing the incident and determining whether the facility's response and corrective actions were appropriate to ensure resident safety.		

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain complete and accurate clinical records for 1 (R #2) of 1 (R #2) resident reviewed, when the facility failed to document required neurological assessments (a physical examination to identify signs of disorders affecting your brain, spinal cord and nerves) after R #2 experienced an unwitnessed fall. This deficient practice is likely to result in staff not having the information they need to provide competent, comprehensive care and services to residents. The findings are: A. Record review of the facility's falls management policy, revised on 01/15/26, revealed the following: Residents who sustained a head injury from a fall or experienced an unwitnessed fall were expected to undergo neurological checks (neuro checks; a brief neurological assessment performed by staff repeatedly to monitor a resident's neurological status) per facility policy. The facility is expected to document the circumstances of the fall, the post-fall assessment, and the patient outcome. B. Record review of R #2's face sheet revealed an admission date of 08/20/23. C. Record review of R #2's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 04/28/26, revealed R #2 had the following diagnoses: Non-Alzheimer's dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). Muscle weakness (generalized). Repeated falls. D. Record review of R #2's nursing progress notes, dated 05/26/26 at 8:20 pm, revealed R #2 was found lying on the bathroom floor after an unwitnessed fall. Neurological checks for R #2 were started per facility protocol after the fall. E. Record review of R #2's electronic health record (EHR), dated 07/30/26, revealed R #2's neurological assessments and follow-ups after the fall on 05/26/26 were not available in R #2's EHR. F. On 07/30/26 at 12:46 pm, during an interview, the DON stated the facility's post-fall neurological monitoring protocol requires neurological assessments every 15 minutes for the first hour, then every 30 minutes for a total of four assessments, followed by an hourly assessment for a total of four assessments. The DON stated the neurological assessments are documented on a paper neurological assessment form that is expected to be uploaded into the resident's EHR. The DON stated the neurological assessment forms for R #2 after the fall on 05/26/26, were not present in R #2's EHR. The DON stated she could not determine whether the neurological assessments had been completed for R #2 because they were not documented in R #2's EHR. The DON stated it was the facility's expectation all required neurological assessments be completed and documented. The DON stated if neurological assessments are not documented, the facility cannot determine whether changes in the resident's condition occurred or whether timely interventions would have been implemented.		