

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/10/2025
NAME OF PROVIDER OR SUPPLIER  Spanish Trails Rehabilitation Suites		STREET ADDRESS, CITY, STATE, ZIP CODE  1610 Renaissance Blvd NE Albuquerque, NM 87107	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</b></p> <p>Based on record review and interview, the facility failed to notify the facility providers (Nurse Practitioner, Physician) and the resident's Emergency Contact (EC), when a resident experienced an unwitnessed fall while also prescribed a blood thinner for 1 (R #2) of 1 (R #2) resident reviewed for a change of condition.</p> <p>This deficient practice is likely to result in a delay in treatment or inadequate treatment. The findings are:</p> <p>A. Record review of R #2's face sheet revealed R #2 was admitted on [DATE] and was discharged to the hospital on 01/13/25.</p> <p>B. Record review of R #2's physician orders dated 01/03/25, revealed R #2 was prescribed and taking Warfarin (blood thinner) 2 milligrams (mg), once a day.</p> <p>C. Record review of R #2's SBAR (Situation, Background, Assessment, and Recommendation- form used to help healthcare professionals communicate quickly) Communication form dated 01/09/25, revealed the Medical Doctor (MD) #1 was contacted at 4:40 am, and R #2's daughter was contacted at 5:40 am after R #2's fall. Note was written by Registered Nurse (RN) #4.</p> <p>D. Multiple attempts to contact RN #4 and never received response.</p> <p>E. Record review of R #2's treatment administration record (TAR) dated 01/08/25 through 01/13/25, revealed the following:</p> <p>1. Post Fall Observation (beginning on 01/09/25): Completed each day without any changes in cognition or pain noted for R #2.</p> <p>2. Observe more frequently and place in supervised area when not in bed (beginning on 01/09/25): Completed twice a day for each day for R #2.</p> <p>F. Record review of R #2's neurological evaluation flow sheet (after R #2's fall) dated 01/09/25 through 01/12/25 revealed no cognitive decline noted after fall that occurred on 01/09/25. R #2's first neurological evaluation occurred on 01/09/25 at 4:30 am.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>G. Record review of R #2's nursing progress notes dated 01/08/25 through 01/13/25, revealed the following:</p> <p>1. On 01/09/25 at 5:24 pm: Fall Follow-up; facility nursing staff spoke to R #2 who stated that he moves around a lot in his sleep. R #2's daughter confirmed that R #2 moves a lot in his sleep and prefers to lay on one side. Bed enablers (a type of bed rail that is used to facilitate movement and provide comfort and security) were added and more frequent visual rounding (observations and medical evaluations) will be conducted for R #2. R #2 and his daughter agreed to the interventions.</p> <p>- This was the only progress note recorded for R #2's fall which occurred on 01/09/25 between the times on 3:00 am to 4:30 am.</p> <p>2. On 01/12/25 at 1:32 pm: R #2's daughter informed the facility nursing staff that R #2 had a bruise to the right side of his temple (temporal bone- fragile part of the skull located on the side of the face). R #2's bruise was purple and yellow in color, and it measured 2.5 centimeters (cm) by 2 cm. R #2 did not know how bruise occurred, but R #2's daughter stated that R #2 had a fall that occurred on 01/09/25.</p> <p>3. On 01/13/25 at 6:28 pm: R #2's family wanted R #2 sent to the hospital for an evaluation due to potential bleeding concerns (related to fall that occurred on 01/09/25). R #2's family called emergency transport (911) for R #2. R #2's family was informed that the facility provider and nurses had evaluated R #2 (after the fall on 01/09/25) and R #2 was being monitored for any signs of distress.</p> <p>H. On 03/06/25 at 11:11 am during an interview with R #2's daughter/EC, she stated that R #2 had a lower pelvis fracture from a fall that occurred on 12/02/24, outside of the facility, but new fractures (single right rib and left rib) occurred after the fall on 01/09/25. R #2's EC also stated R #2 fell on the morning of 01/09/25, but nobody called her from the facility. EC further stated she only found out about the fall after her husband visited R #2 in the facility in the afternoon on 01/09/25, and the facility nursing staff informed him of R #2's fall. R #2's EC stated R #2 began to decline by becoming more lethargic (feeling tired, lacking energy, and sluggish) on 01/010/25 and she noticed R #2's bruise to his face on 01/11/25. R #2's EC confirmed R #2 was complaining of rib pain on 01/13/25, and because he was also on a blood thinner, she called 911 because the facility refused to send R #2 to the ER.</p> <p>I. Record review of R #2's emergency room (ER) note dated 01/13/25, revealed R #2 was brought to the ER after experiencing a fall on 01/09/25, and worsening rib pain. R #2 was diagnosed with a closed fracture of a single right rib and left rib. R #2's ER notes also revealed that R #2 had comprehensive imaging performed in the ER and no acute threatening traumatic injury was found.</p> <p>J. On 03/07/25 at 1:23 pm, during an interview with Licensed Practical Nurse (LPN) #1, she stated that a facility provider should always be notified after a resident experiences a fall, especially if that resident takes a blood thinner medication.</p> <p>K. On 03/10/25 at 12:05 pm, during an interview with Registered Nurse (RN) #1, she stated the providers, the Assistant Director of Nursing (ADON), and Director of Nursing (DON) should be notified when a resident experiences a fall, especially if that resident takes a blood thinner medication.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>L. On 03/10/25 at 2:07 pm, during an interview with the Nurse Practitioner (NP) #1, she stated she was not contacted for R #2's fall on 01/09/25. The NP #1 stated that since R #2's fall occurred in the early morning hours on 01/09/25, she would have expected the facility nursing staff to contact the on-call provider.</p> <p>M. On 03/10/25 at 2:44 pm during an interview with the Assistant Director of Nursing (ADON) #1, she stated when a resident experiences an unwitnessed fall, the nursing staff are to assess the resident and notify a provider immediately. The ADON #1 confirmed after looking at R #2's electronic health record (EHR) that a provider was not notified of R #2's fall on 01/09/25, and one should have been notified.</p> <p>N. On 03/10/25 at 3:23 pm during an interview with the Medical Doctor (MD) #1, he stated the nursing staff does not call him after hours, because he is not available for night calls. The MD #1 also stated that he was not contacted on 01/09/25 at 4:40 am as documented on R #2's SBAR, and he did not know why the nurse documented that. The MD #1 confirmed a provider should have been notified of R #2's fall on 01/09/25 especially since R #2 was taking a blood thinner and he experienced an unwitnessed fall.</p> <p>O. On 03/10/25 at 4:06 pm during an interview with the Director of Nursing (DON), she stated a provider should be notified immediately if a resident experiences an unwitnessed fall while also prescribed blood thinners. The DON confirmed if MD #1 stated that he (MD #1) was not contacted when R #2 experienced a fall on 01/09/25, then a provider was not notified of R #2's fall on 01/09/25 and a provider should have been notified. The DON did not recall being notified of R #2's fall on 01/09/25, and also confirmed R #2's EC should have been contacted immediately as well.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</b></p> <p>Based on record review and interview, the facility failed to provide a quality care that meets professional standards for 1 (R # 2) of 1 (R #2) resident when the facility failed to obtain physician orders prior to providing oxygen (O2).</p> <p>If the facility is providing O2 without physician orders, then residents are likely to not receive the therapeutic benefits and care needed. The findings are:</p> <p>A. Record review of R #2's face sheet revealed R #2 was admitted on [DATE] and was discharged to the hospital on 01/13/25.</p> <p>B. Record review of R #2's O2 saturations (a measure of how much oxygen is in your blood) page located in R #2's electronic health record (EHR) dated 01/03/25 through 01/13/25 revealed R #2 was provided O2 on the following dates:</p> <ol style="list-style-type: none"> <li>1. 01/13/25 at 8:42 am: R #2 was administered 3 liters per minute (LPM) of O2.</li> <li>2. 01/11/25 at 8:02 am: R #2 was administered 2 LPM of O2.</li> <li>3. 01/10/25 at 7:07 pm: R #2 was administered 3 LPM of O2.</li> <li>4. 01/10/25 at 4:54 pm: R #2 was administered 3 LPM of O2.</li> <li>5. 01/08/25 at 6:55 am: R #2 was administered 3 LPM of O2.</li> <li>6. 01/07/25 at 7:45 pm: R #2 was administered 2 LPM of O2.</li> <li>7. 01/07/25 at 8:35 am: R #2 was administered 3 LPM of O2.</li> <li>8. 01/06/25 at 9:28 pm: R #2 was administered 3 LPM of O2.</li> <li>9. 01/05/25 at 7:07 pm: R #2 was administered 3 LPM of O2.</li> <li>10. 01/05/25 at 7:09 am: R #2 was administered 3 LPM of O2.</li> <li>11. 01/04/25 at 7:34 am: R #2 was administered 3 LPM of O2.</li> <li>12. 01/03/25 at 6:57 pm: R #2 was administered 3 LPM of O2.</li> </ol> <p>C. Record review of R #2's physician orders revealed there was not a physician order for O2 use.</p> <p>D. On 03/06/25 at 11:17 am during an interview with R #2's daughter/Emergency Contact (EC), she stated R #2 began wearing O2 at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 03/10/25 at 12:14 pm during an interview with Certified Nursing Assistant (CNA) #2, she stated she remembered R #2 wore O2 when he was in the facility.</p> <p>F. On 03/10/25 at 4:09 pm during an interview with the Director of Nursing (DON), she confirmed R #2 did not have orders for O2 use and he should have. After reviewing R #2's EHR, the DON also confirmed R #2's EHR indicated R #2 used O2 frequently.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>47031</p> <p>Based on observation, record review, and interview, the facility failed to ensure food preference was followed for 1(R #1) of 1 (R #1) resident observed for dining. This deficient practice could result in R #1 not eating his meals and losing weight.</p> <p>A. On 03/06/25 at 10:46 am, during interview with R #1, she stated I can't eat any vegetables, gravy, chocolate, mashed potatoes, corn dog, chicken salad, and mushrooms and they keep giving me vegetables, gravy, chocolate, mashed potatoes, corn dog, chicken salad, and mushrooms.</p> <p>B. On 03/06/25 at 12:45 pm, during an observation of R #1's lunch plate, mashed potatoes were on R #1's plate which she had not eaten.</p> <p>C. Record review of R#1's meal ticket revealed red bold writing, can't eat all vegetables, gravy, chocolate, mashed potatoes, corn dog, chicken salad, and mushrooms.</p> <p>D. On 03/06/25 at 12:52 pm during an interview with Certified Nursing Assistant #1 (CNA), she confirmed R #1 had mashed potatoes on her plate.</p> <p>E. On 03/10/25 at 3:48 pm, during interview with Dietary Manager (DM), he stated R #1 has dietary restrictions and preferences and I am trying to make adjustments to honor her preferences.</p>		