STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 N 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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to follow physician orders for 1 (R #1) of 1 (R #1) resident. This deficient practice is likely to result in residents receiving care that is not medically appropriate. The findings areA. Record review of R #1's face sheet dated 07/10/25 revealed he was admitted to the facility on [DATE] with the following diagnoses:-Gastro Esophageal Reflux Disease (GERD) (a digestive disease in which acid is often regurgitated during/after eating).-Cognitive (mental) Communication Deficit. -Type 2 Diabetes Mellitus (chronic disease affecting blood sugar levels).-Generalized Anxiety (nervousness) Disorder.B. Record review of R #1's physician orders revealed an order dated 01/29/25 to give all medications that are appropriate with food or snack. Ordered by (Name of Medical Doctor).C. On 07/10/25 at 9:20 am during observation and interview with R #1, he was seen in his room, in his bed. He stated he had already received and eaten his meal. He stated he was still waiting for his morning medications to be administered. He stated he preferred to receive his morning medications with his meal as he felt this was less irritating to his stomach. D. On 07/10/25 at 1:20 pm during interview with Licensed Practical Nurse (LPN) #1, she stated this was a nursing order and not a doctor's order and that it should have been discontinued after R #1's return from the hospital. LPN #1 stated that R #1 had stated in the past that he wanted his medications with meals. She stated R #1 had been sent to the hospital a week before (on 07/02/25). LPN #1 stated she discussed medications with R #1 when he returned from the hospital. She stated that after this discussion, she should have discontinued this order as he no longer needed his medications with meals. E. On 07/10/25 at 1:40 pm during interview with R #1 in his room with a Hospice Clergy present, R #1 stated he still preferred to receive his medications, especially his morning medication, to be administered with his meal.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	07/10/2025

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 N 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)
F 0842 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 and interview, the facility failed to accurately document the changing conditions of 1 (R #3) of 3 (R #2, 3, 4) residents. The facility documented conflicting resident daily assessments for R #3's conditions. This deficient practice is likely to result in resident care and care plans being confusing and inadequate. The findings are: A. Record review of R #3's face sheet dated 07/10/25 revealed she was admitted to the facility on [DATE] and discharged from the facility on 05/09/25 to return home with home health services. B. Record review of R #3's Admitting History and Physical dated 03/29/25 revealed she was admitted to the facility with the following diagnosis:-Left Intertrochanteric Femur Fracture (Broken Hip)C. Record review of R #3 Minimum Data Set (a set of assessments that describes a person's needs and abilities: MDS) dated [DATE] revealed the following:-MDS Section C (section that assesses cognitive patterns) Brief Interview for Mental Status (BIMS) (a simple test that assesses a person's mental ability) revealed a score of 10 out of 15 indicating moderate impairment of R #3's memory and cognition.-MDS section G (a set of assessments that describe a person's functional abilities) revealed that upon admission R #3 required stand by assistance with meals and oral hygiene. R #3 required full assistance with toileting and bathing. -MDS Section H (a set of assessments that describe a person's ability to control bowel and bladder) revealed that R #3 was occasionally incontinent of bladder and frequently incontinent of bowel.D. Record review of R #3's care plan dated 03/28/25 stated a problem category of cognitive loss/dementia (a chronic progressive disease that causes decline in memory and mental abilities). E. Record review of R #3's daily nursing notes dated 03/28/25 through 05/09/25, revealed the following: 1. Record review of R#3's daily nursing notes dated 03/28/25 at 11:06 pm revealed R #3 refused all medications. The notes state she reported taking only 3 medications at home. She refused to take the prescribed antibiotic. R #3 was educated as to the need for these medications, why these medications are used and risks of non-compliance. 2. Record review of R#3's daily nursing notes dated 03/29/25 at 5:49 pm revealed R #3 refused continence care (care of the body following an incidence of bowel or bladder release). R #3 was educated on the need for regular continence care to prevent skin breakdown. R #3 stated she didn't need a lecture. R #3 requested a change of room due to bed placement. 3. Record review of R#3's daily nursing notes dated 03/29/25 at 2:05 pm revealed R #3 refused medication.4. Record review of R#3's daily nursing notes dated 03/29/25 at 6:56 pm revealed R #3 refused Tuberculosis (a chronic infectious disease of the lungs) testing stating I don't need it. I don't want it. 5. Record review of R#3's daily nursing notes dated 03/29/25 at 11:55 pm revealed R #3 insisted that she doesn't want to be bothered during the night and that she doesn't want to be checked for incontinence (inability to control bowel and/or bladder) needs. R #3 stated she was tired of being bothered. 6. Record review of R#3's daily nursing notes dated 03/31/25 at 3:11 pm revealed R #3 refused all meds. R #3 refused continence care (a check by staff to determine if resident has had an episode of incontinence). R #3 was educated on the need for regular incontinence care, R #3 responded that she already knew this.7. Record review of R#3's daily nursing notes dated 04/01/25 at 12:19 pm revealed R #3 met with Assistant Director of Nursing (ADON) to discuss her ongoing refusal of medication and care needs. R #3 stated she will not follow current recommendations as she knows better than those of us here who are not educated enough to manage her care. Nurse Practitioner (NP) #1 was notified and informed of R #3's refusals. A referral was ordered to counseling services.8. Record review of R#3's daily nursing notes dated 04/04/25 at 6:39 pm revealed R #3 refused to have her surgical dressing changed told staff it looked good to her. The nurse again explained the importance of daily care needs and concern for R #3's continued refusal of antibiotics. R #3 told the nurse to leave now and close the door.9. Record review of R#3's daily nursing notes dated 04/04/25 at 9:30 pm revealed R #3 refused care and insisted she be left alone until the morning. The nurse explained the need for regular incontinence checks and regular incontinence care. R #3 informed the nurse she would think about it.10. Record review of R#3's daily nursing notes dated 04/08/25 at 12:59 pm revealed R #3 refused to be weighed.11. Record review of R#3's daily nursing notes dated 04/09/25 at 12:46 pm revealed R #3 refused medications. R #3 was educated about their medications and the need to take prescribed dosages. NP #1 was notified of the refusal.12. Record review of R#3's daily nursing notes dated 04/19/25 at 6:55 pm revealed R #3 refused three times-wound care and shower/bed bath stating she did not want to be disturbed.13. Record review of R#3's daily nursing notes dated 04/22/25 at 11:03 am revealed R #3 was provided information for home health care in planning for a safe discharge. R #3 stated she wanted to be