

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 12/23/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on observation, record review, and interview, the facility failed to consider and provide the preferences of (R #81) of 1 (R #81) residents reviewed when the facility failed to assist R #81 with purchases that reflected R #81's interests after R #81 asked the facility staff for assistance. These deficient practices are likely to result in the resident's personal choices not being honored. The findings are:</p> <p>R #81:</p> <p>A. Record review of R #81's face sheet revealed R #81 was admitted into the facility on [DATE].</p> <p>B. Record review of R #81's care plan, dated 01/23/24, revealed R #81 liked to watch TV, paint, read, and use his computer. Staff to ensure R #81 had materials for individual activities as desired and materials for painting.</p> <p>C. On 12/17/24 at 9:34 am during an interview with R #81, he stated he was unable to purchase his painting materials and additional winter clothes. R #81 also stated the previous Social Services Director (SSD) would assist him with purchasing those items, but nobody offered to help him after the previous SSD left the facility. R #81 confirmed he asked the facility staff for assistance multiple times, but they did not help him purchase the items. R #81 stated he did not have family around to help him.</p> <p>D. On 12/23/24 at 10:32 am during an interview with the Administrator (ADM), she stated the previous SSD would assist R #81 with his online purchases, but nobody in the facility helped R #81 after the previous SSD left the facility. The ADM stated R #81 liked to purchase his painting materials online, and he wanted someone to help him make online purchases. The ADM confirmed R #81 should have been assisted with his online purchases, but he was not.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 325131
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>41988</p> <p>Based on record review and interview, the facility failed to conduct an in-depth investigation and correct the grievance allegation for 1 (R #34) of 1 (R #34) residents reviewed for the outcomes and resolutions of their grievances. This deficient practice could likely result in the facility not considering the needs of the residents or adequately resolving their grievances and lead to a decrease in resident quality of life. The findings are:</p> <p>A. Record review of R #34's grievance report, dated 12/12/24, revealed the following:</p> <ul style="list-style-type: none"> - Grievance Details: R #34 stated he deserved a hot meal, and he was tired of eating cold food that was also stiff. R #34 had to pull hair out of his food multiple times and stated the amount of hair in his food sometimes feels like spaghetti. R #34 also stated that he was legally blind, and the CNAs were not available to assist him with a brief change for one to two hours. - Investigation: Social Services Director (SSD) checked on R #34's food for breakfast. The food was warm but not to R #34's liking. No other investigation notes present. - Summary of Investigation: R #34 was located at the end of the unit, and his food reached his room later than other residents. R #34 was offered to eat his meals in the main dining room, but he refused. No other investigation notes present. - Summary of Findings: Food was warm, but food temperature could not be checked. No other investigation notes or findings present. <p>Summary of Actions Taken: Dietary staff and delivery staff were notified. No other notes present.</p> <ul style="list-style-type: none"> - Grievance resolved by SSD on 12/17/24. <p>B. On 12/23/24 at 1:57 pm during an interview with R #34, he stated the SSD addressed his grievance report, dated 12/12/24. R #34 stated he was only aware of the cold food concern being investigated and not the rest of the grievance. R #34 confirmed the meals were a little warmer since he filed a grievance, but they were mostly cold still. He stated he did not think his grievance was resolved.</p> <p>C. On 12/23/24 at 2:11 pm during an interview with the SSD, he stated he did not take the temperature or have someone else take the temperature of R #34's food prior to resolving the grievance. The SSD stated R #34's cream of wheat looked warm due to steam condensation present on the lid of the bowl. The SSD stated the dietary staff went to talk to R #34, and he believed R #34 was satisfied with the grievance investigation. The SSD stated he only investigated the food portion of the grievance, because R #34's grievance was addressed by the team. The SSD stated he was not responsible for any other parts of R #34's grievance, and he closed the grievance.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. On 12/23/24 at 2:15 pm during an interview with the Administrator (ADM), she stated staff did not investigate R #34's grievance, dated 12/12/24, appropriately for each allegation, but they should have. The ADM stated staff should not have documented that R #34's grievance was resolved until R #34 was satisfied with the investigation and findings.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on record review and interview, the facility failed to ensure staff revised the care plan for 2 (R #35 and #90) of 2 (R #35 and #90) residents reviewed when staff failed to conduct a quarterly care plan meeting as required. This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are:</p> <p>R #35:</p> <p>A. Record review of R #35's face sheet revealed R #35 was admitted into the facility on [DATE].</p> <p>B. Record review of R #35's care conference (care plan meeting) report revealed R #35's last care plan meeting occurred on 07/24/24. Staff did not document any other care plan meetings as completed after 07/24/24.</p> <p>C. On 12/18/24 at 2:43 pm during an interview with R #35, he stated he did not remember having a care plan meeting for a while.</p> <p>D. On 12/18/24 at 3:50 pm during an interview with the Social Services Director (SSD), he stated R #35 should have had a care plan meeting since 07/24/24. The SSD stated R #35 did not have a quarterly care plan meeting as required, but he should have had one.</p> <p>R #90:</p> <p>E. Record review of R #90's face sheet revealed R #90 was admitted into the facility on [DATE].</p> <p>F. Record review of R #90's care conference report revealed R #90's last care plan meeting occurred on 07/16/24. Staff did not document any other care plan meetings as completed after 07/16/24.</p> <p>G. On 12/17/24 at 10:19 am during an interview with R #90, she stated she has not had a care plan meeting in some time, but she would like to have one.</p> <p>H. On 12/18/24 at 3:47 pm during an interview with the SSD, he stated R #90 needed a care plan meeting, because she did not have one since 07/16/24. The SSD stated R #90 did not have a quarterly care plan meeting as required, but she should have had one.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509</p> <p>Based on observation, record review and interview, the facility failed to meet professional standards for 2 (R #7 and #122) of 2 (R #7 and #122) residents reviewed when staff failed to:</p> <ol style="list-style-type: none"> 1. Ensure labs were reviewed and critical results conveyed to the medical provider in a timely manner. 2. Ensure medications were available for administration. <p>If the facility fails to administer medications as prescribed by the physician, then residents are not likely to receive the therapeutic value of medications prescribed. If the facility fails to relay lab results, then the physician is unable to properly monitor and assess the physical condition of the resident. The findings are:</p> <p>R #7</p> <p>A. Record review of R #7's face sheet, dated 12/23/24, revealed she was admitted to the facility on [DATE] with multiple diagnoses including the following: Add punctuation to the end of each entry in the list below.</p> <ul style="list-style-type: none"> - Diabetes (failure of the body to properly process and balance blood sugar), - Chronic kidney disease (a chronic failure of the functioning of the kidneys), - Depression (feeling of sadness and hopelessness), - Cognitive communication deficit (difficulty communicating with others due to mental decline.) <p>B. Record review of R #7's daily notes revealed staff documented the following: :</p> <ul style="list-style-type: none"> - On 11/06/24 at 1:55 pm, R #7 vomited a dark brown vomit after breakfast. Provider notified and ordered labs. - On 11/06/24 at 2:30 pm, order received from provider for immediate) complete blood count (CBC; a lab test to measure blood components) due to dark emesis (vomit) and abdominal pain. - On 11/07/24 1:02 pm, R #7 was sent to local hospital by provider. - On 11/11/24 4:15 pm, R #7 returned to the facility from the local hospital. <p>C. Record review of R #7's laboratory result of CBC, dated 11/06/24 at 6:44 pm, revealed the results of the test and a hemoglobin (red blood cells) count of 6.7 (12-16 is normal count range.) The results indicated this was a critical value.</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 - Some</p>	<p>D. On 12/18/24 9:16 AM during an interview with Registered Nurse (RN) #1, she stated an unnamed Certified Nurses Aide (CNA) notified her the morning of 11/06/24 that R #7 vomited dark brown emesis. RN #1 reported she called the provider and was given an order to immediately draw blood for an immediate CBC. RN #1 said she drew the resident's blood and contacted the lab to come pick it up.</p> <p>E. 12/23/24 12:46 PM during interview with Director of Nursing (DON), she confirmed R #7 reported vomiting on the morning of 11/06/24. She stated the nurse drew the resident's blood for a lab, and the lab results indicated a critical value reported on 11/06/24 at 6:47 pm. She stated staff should have reported the results to the provider immediately. She stated all lab values are called to the facility and sent by fax. She stated she could not explain why staff did not report the lab result to the provider immediately.</p> <p>F. On 12/23/24 1:01 PM during interview with the Physician Assistant (PA), she stated she was notified of R #7's condition on 11/06/24 at 2:30 PM. She stated she suspected a gastrointestinal (GI) bleed (a condition in which the lining of an unspecified area of the gastrointestinal tract was irritated and bleeding.) She stated she wanted the CBC done and results returned immediately. She confirmed she did not receive the results of the CBC until 11/07/24 at 1:00 PM, which delayed the decision to send R #7 to the hospital for evaluation. The PA stated the CBC results indicated R #1 needed a blood transfusion. She stated R #1's condition was urgent but not life threatening.</p> <p>G. On 12/24/24 9:44 AM during phone interview with a laboratory representative, she stated she reviewed R #7's laboratory results. She stated the lab results for R #7 were reported as critical values. She stated a person from the laboratory called the facility on 11/06/24 at 6:47 pm and 11/06/24 at 7:18 pm, but staff did not answer the phone. She stated the same laboratory representative called the facility again on 11/06/24 at 7:57 pm and reported the lab results to the DON. The laboratory representative stated the lab results were sent to the facility via fax on 11/06/24 at 6:47 pm and again after phone contact with DON.</p> <p>R #122</p> <p>H. On 12/19/24 at 8:20 am during observation of medication administration to R #122, RN #2 administered medications to R #122. He did not draw and administer Eliquis (a medication used to prevent and treat blood clots), 5 milligrams (mg) to R #122.</p> <p>I. Record review of R #122 provider orders, dated 12/17/24, revealed an order for Eliquis, 5 mg, once a day at 7:00 am.</p> <p>J. Record review of R #122 Medication Administration Record (MAR) revealed Eliquis, 5 mg, was to be administered on 12/19/24 at 7:00 am. Further review revealed RN #2 documented the medication was not given due to the medication was unavailable.</p> <p>K. On 12/19/24 at 3:21 pm during interview with RN #2, he stated he did not administer Eliquis 5 mg to R #122 during the observed medication pass. He stated the medication was not available, and he did not attempt to get the medication from the facility's Pyxis (a storage device that contains most of the commonly prescribed medications. Is used as an additional source of medications.)</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 - Some</p>	<p>L. On 12/23/24 at 12:46 pm during interview with Director of Nursing (DON), she stated medications should be administered as ordered by the provider, and staff should check the Pyxis for a medication that was not available in the medication cart. The DON stated if the medication was not available in the Pyxis, then staff should contact the provider. The DON stated Eliquis would be available in the Pyxis, and the nurse should have gotten Eliquis from the Pyxis or notified the provider that the medication was not available for administration.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39509</p> <p>Based on observation, interview and record review, the facility failed to ensure the medication error rate did not exceed 5 percent (%) when staff performed six medication errors out of 26 opportunities for 2 (R #118 and 122) of 6 (R #66, 89, 90, 118, 122) residents reviewed during medication administration. This resulted in a medication error rate of 23.08%. If residents are not informed of the medications they are receiving, then residents do not have the ability to accept or reject the medications being administered. The findings are:</p> <p>A. On 12/19/24 at 8:14 am during observation of Registered Nurse (RN) #2 administering medications, he poured and administered the following medications to R #118:</p> <ul style="list-style-type: none"> - Amlodipine (medication to manage blood pressure) 10 milligrams (mg), - Aspirin (medication prescribed to reduce blood clotting factors) 81 mg, - Atorvastatin (medication prescribed to reduce blood fats and cholesterols) 20 mg. <p>B. Record review of R #118's physician orders revealed the following:</p> <ul style="list-style-type: none"> - Dated 12/12/24, amlodipine 10 mg once a day at 7:00 am, - Dated 12/12/24, aspirin 81 mg once a day at 7:00 am, - Dated 12/12/24, atorvastatin 20 mg once a day at 7:00 am. <p>C. On 12/19/24 at 8:20 am during observation of RN #2 administering medications, he poured and administered the following medications to R #122:</p> <ul style="list-style-type: none"> - Vitamin D3 (nutritional supplement) one tablet, - Senna (medication prescribed to prevent constipation) one tablet. <p>D. Record review of R #118's physician orders revealed the following:</p> <ul style="list-style-type: none"> - Dated 12/17/24, vitamin D3, one tablet once daily at 7:00 am, - Dated 12/18/24, senna, one tablet once daily at 7:00 am, - Dated 12/17/24, Eliquis (medication prescribed to treat and prevent blood clots) 5 mg once daily at 7:00 am. <p>E. On 12/19/24 at 3:21 pm during interview with RN #2, he stated he administered morning medications as ordered. He stated the Eliquis was not available to be administered.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. On 12/20/24 at 9:35 am during interview with Assistant Director of Nursing (ADON) #1, she stated staff are to administer within one hour before or after the scheduled time. She stated if medications are not administered during this time, then medications would be considered late.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509</p> <p>Based on observation, record review, and interview, the facility failed to provide food to accommodate resident preferences for 1 (R #225) of 1 (R #225) residents observed for food preferences. This deficient practice is likely to result in resident frustration and weight loss due to the resident not receiving and eating their preferred diet. The findings are:</p> <p>R #225:</p> <p>A. Record review of R #225's face sheet, dated 12/23/24, revealed she was admitted to the facility on [DATE].</p> <p>B. Record review of R #225's physician dietary order, dated 12/13/24, revealed she was to receive the house (regular) diet.</p> <p>C. Record review of R #225's Diet Order and Communication, dated 12/13/24, revealed R #225 was to receive a regular diet with no pudding or sweet desserts. The admitting nurse signed the order.</p> <p>D. On 12/16/24 at 2:30 pm during observation of R #225's room, she had multiple food items stacked on her room shelf. The foods were all labeled as vegan compliant.</p> <p>E. On 12/19/24 at 1:30 pm during observation of R #225's meal tray, she had country fried steak with gravy, mashed potatoes, and a cup of sherbet. The meal tray had a slip that listed the resident's name and her menu as house (regular) diet. The resident ate the vegetables that came with the meal, but she did not eat the country fried steak, mashed potatoes, gravy, or sherbet.</p> <p>F. On 12/16/24 at 2:30 pm during an interview with R #225, she stated she ate a vegan diet for many years. She stated she notified the admitting nurse after she was admitted that she was vegan and preferred to remain on her vegan diet. R #225 stated she told several of the Certified Nurse Aides (CNAs) that she was vegan, but they continued to deliver the same regular menu. She stated since her admission, she did not receive any vegan meals. She stated her morning meal was eggs, bacon, milk, and coffee. She stated she contacted her family and friends and asked them to bring vegan foods to her. She stated she has not met with anyone from the kitchen and discussed her meal preferences.</p> <p>G. On 12/19/24 at 1:06 pm during interview with Registered Nurse (RN) #2 he stated he was the admitting nurse for R #225. He stated he did not recall R #225 telling him that she was vegan so he entered her diet as regular.</p> <p>H. On 12/23/24 at 11:44 am during interview with the RD, she stated the Kitchen Manager generally met with and interviewed all residents of their dietary preferences. She stated this was usually done within the first days after the resident's admission. She stated the Kitchen Manager was on leave for the past week and was not due back for another week. The RD stated staff did not conduct an interview of R #225's preferences, and R #225 did not receive her preferred vegan diet.</p> <p>(continued on next page)</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>I. On 12/23/24 at 1:30 pm during interview with CNA #1, she stated she delivered meals to R #225. She stated she was told R #225 preferred a vegetarian diet, but she did not know R #225 was vegan. She stated she continued to deliver meals as they were provided by the kitchen.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>47031</p> <p>Based on observation, record review, and interview, the facility failed to provide a therapeutic diet as ordered by a Physician for 1 (R #64) of 1 (R #64) residents reviewed during random dining observations. If the facility fails to provide a diet as ordered, then residents are likely to experience weight loss due to not receiving their prescribed nutritional caloric intake. The findings are:</p> <p>A. Record review of Dietary Census List, dated 12/23/24, revealed R #64 was on a regular pureed diet (a texture modified diet that requires no chewing.)</p> <p>B. Record review of R#64's care plan, dated 12/19/2024, revealed R #64 was on a regular pureed diet, start date 04/05/24.</p> <p>C. Record review of R#64's Dietary Meal ticket, dated 12/23/24, revealed staff to provide a therapeutic diet (a meal plan prescribed by a doctor or dietician that controls the intake of foods or nutrients as part of a treatment.)</p> <p>D. On 12/16/24 at 12:40 pm during a lunch observation, staff served R #64 pureed mashed potatoes, pureed carrots, and mechanical soft (a texture modified diet that requires some chewing but less than a regular diet) meatloaf.</p> <p>E. On 12/16/24 at 12:43 pm during an interview with Dietary [NAME] (DC) #1, he stated R #64's meal ticket indicated R #64 was to receive a pureed diet, but R #64 was served a mechanical soft meatloaf instead. DC #1 stated staff should not have served R #64 mechanical soft meatloaf, but they should have served R #64 pureed meatloaf.</p>

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 12/23/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41988</p> <p>Based on record review, observation, and interview, the facility failed to ensure meals were served at a safe and appetizing temperature for 4 (R #34, #43, #72, and #84) of 4 (R #34, #43, #72, and #84) residents reviewed for meal quality. This deficient practice is likely to lead to foodborne illnesses if staff do not maintain food temperatures outside of the danger zone [between the temperatures of 45 degrees () Fahrenheit (F) and 135 F; the temperature range in which food-borne bacteria can grow.) The findings are:</p> <p>A. On 12/17/24 at 9:55 am during an interview with R #84, she stated her food was usually cold when she received it in her room. R #84 stated she would like her food to be warmer. She stated she has the nursing staff the food was served cold, but staff continued to serve her food cold.</p> <p>B. On 12/17/24 at 1:28 pm during an interview with R #43, he stated his food was often cold, and he did not like that. R #43 stated his food was cold when he ate in his room and in the dining room. R #43 stated he told staff about his food being cold, but it did not change anything.</p> <p>C. On 12/23/24 at 12:13 pm during an observation, staff served food from the steam table to the residents. The staff served R #72 chicken nuggets and French fries from the steam table. Further observation revealed the food on the steam table measured the following:</p> <ul style="list-style-type: none"> - Meatless baked ziti: 55.4 F. - Pureed baked ziti: 89.3 F. - Ground beef: 84.1 F. - French fries: 36.4 F. <p>D. On 12/23/24 at 12:14 pm during an interview, [NAME] (CK) #1 confirmed the findings and stated the steam table was broken and did not keep food in the safe temperature range (hot foods should be held at 135 F or higher on the steam table.) CK #1 stated the food was not at the appropriate temperature to be served to residents.</p> <p>E. On 12/23/24 at 1:08 pm during an interview with R #72, she stated she could not eat her fries, because they were too cold. R #72 stated her food was often served too cold, and she would like it warmer.</p> <p>F. On 12/23/24 at 1:31 pm during an interview with the Registered Dietitian (RD), she stated the steam table food temperatures were not at safe temperatures to be served to the residents.</p> <p>G. Record review of R #34's grievance report, dated 12/12/24, revealed R #34 stated he was tired of eating cold food, and he deserved a hot meal.</p> <p>(continued on next page)</p>		

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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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. On 12/23/24 at 1:55 pm during an interview with R #34, he stated over the weekend (12/21/24 and 12/22/24) the food was very cold, and he could not eat it. R #34 stated the food was served too cold a lot of the times, and that was why he filed the grievance on 12/12/24.</p> <p>I. On 12/23/24 at 2:42 pm during an interview with the Administrator (ADM), she stated she told the dietary staff not to serve the cold food from the steam table, and they needed to reheat it to a safe temperature. The ADM stated the cold food from the steam table should not have been served to the residents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39509</p> <p>Based on observation and interview, the facility failed to assure staff followed infection control practices for 2 (R #118 and #122) of 2 (R #118 and #122) residents when Registered Nurse (RN) #2 did not wash his hands before and after he administered medications to residents. This deficient practice has the potential to spread infectious diseases between residents. The findings are:</p> <p>A. On 12/19/24 at 8:14 am during observation of medication administration, RN #2 drew and poured medications for R #118 into a medication cup. He took the medications to the resident, administered the medications, and returned to the medication cart. RN #2 then began to draw and pour medications for R #122 into a medication cup. RN #2 took the medications to the resident, administered the medications and returned to the cart. RN #2 did not wash his hands before, during, or after pouring and passing medications to the residents.</p> <p>B. On 12/19/24 at 8:20 am during an interview with RN #2, he stated he usually used the hand wash stations in the resident rooms. He stated he did not wash his hands during the medication administration, but he should have.</p> <p>C. On 12/23/24 at 12:46 pm during interview with Director of Nursing (DON), she stated staff should always wash hands before and after administering medications to a resident.</p>