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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on interview and record review, the facility failed to promote care with dignity and respect for 1 (R #1) of 1 (R #1) resident reviewed for residents' rights by walking into the room to speak to a staff member who's performing personal care on a resident. This deficient practice is likely to result in residents feeling as if they were unimportant and not having privacy. The findings are: A. On 04/22/25 at 12:30 PM during an interview with R #1, she stated that she felt a nurse did not treat her with respect when she went into the bathroom without announcing herself when she was showering. The nurse needed to talk to the Certified Nurse Aide (CNA) who was assisting me with my shower. R #1 further stated, Just because she's a nurse doesn't mean it's okay to just go into someone's bathroom to talk to another staff. I felt like she didn't respect my privacy. B. Record review of R #1's face sheet revealed she was admitted to the facility on [DATE]. C. Record review of R #1's Minimum Data Set (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 03/07/25, revealed the following: - Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15. - Functional Abilities-Shower/bathe self: 02. Substantial/maximal assistance. D. On 04/25/25, at 9:39 AM, during an interview with the Assistant Director of Nursing (ADON #2), she stated that R #1 has never mentioned anything about a nurse making her feel uncomfortable or disrespected. She added that if R #1 did feel uncomfortable or disrespected in any way, it would be a concern that she would look into. The expectation for staff entering a room where a resident is receiving personal care is that they knock and announce themselves before entering. E. On 04/25/25, at 10:22 AM, during an interview with CNA #1, she stated that R #1 only allows certain staff members to assist her with showers/care. She will openly say, 'It's not that I don't like you, but I don't like the way you do things, and I'll wait for my care to be done by staff I prefer.' CNA #1 further stated, R #1 likes things done in a specific way, and if you follow her preferences without taking offense, you'll get along with her and gain her trust. R #1 is very vocal and straightforward about expressing her opinions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 04/25/25, at 2:22 PM, during an interview with the Director of Nursing (DON), she stated that the expectation for entering a resident's room, bathroom, or shower room is that staff should knock, wait to be allowed in, acknowledge the residents, and inform them they need to speak briefly with the other staff members. She added that R #1 has not brought up this incident to her. She also mentioned that she would be conducting training to remind staff about the protocol for entering rooms when personal care is being provided. G. On 04/25/25, at 2:45 PM, during an interview with R #1's roommate, she confirmed that the incident with the nurse walking in unannounced while R #1 was showering did occur. She further stated that R #1 was upset and felt like her privacy was violated.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Repeat Deficiency from 03/10/25 Based on record review and interview, the facility failed to notify the resident's provider or Emergency Contact (EC) of the resident's change in condition for 1 (R #30) of 2 (R #15 and #30) residents reviewed for changes of condition (new or worsening symptoms). If the facility is not notifying the provider and EC when the resident experiences a change of condition, then both would be unable to make decisions related to treatment and advocate for the resident's care. The findings are: A. Record review of R #30's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: -Acute Respiratory (breathing) Failure with Hypoxia (low blood oxygen). -Heart Failure. -Unspecified Kidney Disease. -Malignant (cancer) Neoplasm (tumor) of upper third of Esophagus (throat). The face sheet further revealed the name and phone number of an EC for R #30. B. Record review of R #30's daily care notes revealed the following: -02/06/25 R #30 was sent to the hospital by R #30's dialysis (process of mechanically exchanging toxic elements from the blood) provider due to being short of breath. The note did not contain any indication that the provider or EC was contacted and told of the transfer. -02/25/25 R #30 was sent to the hospital by R #30's dialysis provider due to a lab hemoglobin (red blood cell that transport oxygen through out the body) value that was low. The note did not contain any indication that the provider or EC was contacted of the transfer. -03/01/25 R #30 was sent to the hospital by R #30's dialysis provider due to a lab hemoglobin value that was low. The note did not contain any indication that the provider or EC was contacted of the transfer. -04/13/25 R #30's left arm was moderately swollen. The provider was notified and ordered R #30 be transferred to hospital for evaluation. Transport was arranged. The note did not contain any indication that the EC was contacted and told of the transfer. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 04/22/25 at 3:30 pm during interview with Registered Nurse #1, he stated that R #30 was being transferred to the hospital to have a blood transfusion. RN #1 stated that he had called the provider with lab results earlier and was directed to transfer R #30 to the hospital. RN #1 stated he should be calling the EC to inform him of the transfer and that contacting the EC was required with each transfer to the hospital. There is no indication that EC had been contacted on 02/06/25, 02/25/25, 03/01/25 and on 04/13/25. RN #1 confirmed EC had not been contacted according to daily care notes.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to complete a timely assessment for 1 (R #15) of 2 (R #15 and #30) residents reviewed for hospitalization s and had a sufficient change (a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions) within 14 days of the significant event. This deficient practice could likely result in residents not receiving the care and assistance needed. The findings are: A. Record review of R #15 face sheet dated 04/29/25 revealed he was admitted to the facility on [DATE] with the following diagnoses: -Paranoid (unreasonable suspicious thoughts) Schizophrenia (a psychiatric condition characterized by a disconnect from reality). -Psychotic (a psychiatric condition characterized by disorganized speech and behavior) Disorder with Delusions (unreal thoughts). -Chronic Kidney Disease -Diabetes (a condition that the body is unable to control blood sugars). -Dysphagia (difficulty swallowing). B. Record review of R #15's daily care notes revealed the following: -03/21/25 at 7:15 pm, R #15 needs help holding his head up, reduced strength of arms and legs and slurred speech. Facility nurse practitioner (NP) contacted, and order given to transfer R #15 to the hospital for evaluation. 04/14/25 at 10:12 pm, R #15 has returned from the hospital to the facility. C. Record review of R #15's Minimum Data Set (MDS: a group of assessments that indicates a person's overall needs and abilities) revealed that on 03/21/24, a MDS documentation of Discharge Return Anticipated was completed and submitted. On 04/14/25 an MDS documentation of Entry was completed and submitted. D. On 04/25/25 at 5:23 pm during interview with the Director of Nursing (DON) and MDS coordinator, they stated that they were unsure if an MDS change of condition should be completed when R #15 was transferred to the hospital. They stated they had completed the MDS for his Discharge with Return Anticipated and then completed the MDS for his return.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure staff revised the care plan for 6 (R #'s 1, 54, 55, 70, 73, and 79) of 6 (R #'s 1, 54, 55, 70, 73, and 79) residents reviewed when staff failed to: 1. Conduct a quarterly care plan meeting as required for R #'s 1, 54, 55, 70, and 73 in accordance with their admitted and Minimum Data Set (MDS) assessments. 2. Update R #79's plan of care to include resident and resident's family assistance with colostomy (surgery to create an opening for the colon (large intestine) through the abdomen). These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: Care Plan Meetings: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's MDS resident assessment page located in R #1's Electronic Health Record (EHR) revealed R #1's last two quarterly MDS assessments occurred on 09/09/24 (quarterly review) and 12/05/24 (quarterly review). C. Record review of R #1's care conference report reviewed on 04/24/25 revealed R #1 had a care plan meeting on 09/19/24 and then one was not conducted until 01/28/25. R #54: D. Record review of R #54's face sheet revealed R #54 was admitted into the facility on [DATE]. E. Record review of R #54's MDS resident assessment page located in R #54's EHR revealed R #54's last two quarterly MDS assessments occurred on 10/27/24 (quarterly review) and 01/27/25 (annual review). F. Record review of R #54's care conference report reviewed on 04/24/25 revealed R #54 had a care plan meeting on 11/12/24 and then one was not conducted until 04/17/25. R #55: G. Record review of R #55's face sheet revealed R #55 was admitted into the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #55's MDS resident assessment page located in R #55's EHR revealed R #55's last two quarterly MDS assessments occurred on 12/05/24 (quarterly review) and 03/07/25 (annual review). I. Record review of R #54's care conference report reviewed on 04/24/25 revealed R #54 had a care plan meeting on 12/17/24 and then one was not conducted until 04/24/25. R #70: J. Record review of R #70's face sheet revealed R #70 was admitted into the facility on [DATE]. K. Record review of R #70's MDS resident assessment page located in R #70's EHR revealed R #70's last two quarterly MDS assessments occurred on 11/21/24 (quarterly review) and 02/18/25 (annual review). L. Record review of R #70's care conference report reviewed on 04/24/25 revealed R #70 had a care plan meeting on 11/14/24 and then one was not conducted until 03/11/25. R #73: M. Record review of R #73's face sheet revealed R #73 was admitted into the facility on [DATE]. N. Record review of R #73's MDS resident assessment page located in R #73's EHR revealed R #73's last two quarterly MDS assessments occurred on 11/15/24 (quarterly review) and 02/15/25 (annual review). O. Record review of R #73's care conference report reviewed on 04/24/25 revealed R #73 had a care plan meeting on 08/15/24 and then one was not conducted until 01/28/25. P. On 04/24/25 at 5:28 pm during an interview with the Director of Nursing (DON), she stated all care plan meetings should be conducted every 90 days (quarterly). The DON confirmed R #'s 1, 54, 55, 70, and 73 care plan meetings were not completed quarterly, and should have been. Updated Care Plan: R #79: Q. Record review of R #79's face sheet revealed R #79 was admitted into the facility on [DATE]. R. Record review of R #79's physician orders dated 04/03/25 revealed the facility nursing staff were to change R #79's colostomy wafer and pouch weekly and as needed. S. Record review of R #79's care plan dated 04/11/25 revealed R #79 has a colostomy, but R #79 and/or R #79's family providing colostomy care was not care planned. T. On 04/22/25 at 4:28 pm during an interview with R #79's father, he stated that his wife (R #79's mother) or him will change R #79's colostomy bag most of the time. R #79's father also stated that the facility nurses will help, but the nurses are aware of them providing colostomy care for R #79. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	U. On 04/25/25 at 4:21 pm during an interview with the Assistant Director of Nursing (ADON) #1, she stated that sometimes R #79 and R #79's parents will provide colostomy for him. The ADON #1 also stated the facility nurses will complete colostomy care for R #79 when his parents are not around. The ADON #1 confirmed R #79 and R #79's parents providing colostomy care for R #79 should be care planned, and it was not.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. Food items were labeled and dated in the kitchen refrigerator and freezer. 2. Food was stored appropriately and not left open to air in the kitchen freezer. 3. Food items were not expired in the kitchen and dry storage. These deficient practices are likely to affect all 117 residents listed on the resident census list provided by the Administrator on [DATE] and are likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On [DATE] at 11:43 am, observation of the kitchen revealed the following: 1. Three large cheese pizzas were not labeled or dated and stored in the kitchen freezer. 2. One large cardboard box of green beans were left open to air and stored in the kitchen freezer. 3. Thirteen 24 count plastic containers of chocolate chip cookies was not labeled or dated and stored in the kitchen dry storage. 4. One 5 pound (lb) and 5 ounce (oz) package of La Banderita yellow corn tortillas had an expiration date of [DATE], and an opened dated of [DATE], was stored in the kitchen dry storage. 5. Two 12 count packages of Natures Own hamburger buns had an expiration date of [DATE], and was stored in the kitchen dry storage. 6. One 12 count package of Natures Own hotdog buns had an expiration date of [DATE], and was stored in the kitchen dry storage. B. On [DATE] at 12:10 pm during an interview with the Dietary Manager (DM), she confirmed all findings listed above and stated that all food items should be labeled, dated, stored appropriately, and not expired.