STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325034	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Albuquerque	5900 Forest Hills Drive NE Albuquerque, NM 87109

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PAST NON-COMPLIANCEBased on record review and interviews, the facility failed to ensure residents were free from misappropriation of property for 1 (R #2) of 1 (R #2) resident reviewed, when a transport driver took money from a resident. This deficient practice could result in financial loss, emotional distress, and compromise of resident trust and safety. The findings are: A. Record review of the facility's Code of Conduct revealed staff were not to ask for or accept tips, gifts, loans, and/or monetary transactions from residents or their family members. Further review revealed the facility has a zero tolerance for any type of misappropriation or exploitation. B. Record review of the facility's follow-up investigation report, dated 11/19/25, for misappropriation of resident property identified the following corrective actions: All drivers were re-educated of the facility's zero-tolerance policy against misappropriation of resident property. A sign was placed in each transportation van to indicate to residents and family members tips were strictly prohibited and would subject the driver to disciplinary action.C. Record review of the Driver Training Sign-In Sheet, dated 11/24/25, revealed 14 drivers received training on the facility's Code of Conduct with example of how drivers were not to ask for or accept tips, gifts, loans, and/or monetary transactions from residents or their family members.D. Record review of R #2's face sheet revealed R #2 was originally admitted to the facility on [DATE].E. Record review of R #2's minimum data set (MDS, which was part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) completed on 10/16/25 indicated R #2 had a brief interview for mental status (BIMS; screening for cognitive impairment) score of 15 (score of 15 - 13 is cognitively intact). F. On 12/11/25 at 1:40 pm, during interview with R #2, he stated on 10/24/25 he left the facility to go to the bank. R #2 stated his transport driver accompanied him into the bank. R #2 stated the driver recounted stories about his family and mentioned needing money multiple times. R #2 stated driver spoke about how his family had a history of being upstanding people who always paid others back. R #2 stated he felt inclined to loan the driver $100, and the driver told him he would pay resident back with his next paycheck. R #2 stated after about a month, he hadn't heard from the driver and went up to the front desk where he requested staff to call the driver so he could speak to him. R #2 stated this is when he felt the driver was not going to pay him back. R #2 stated he was going to let the situation go but the facility intervened. R #2 stated he was appreciative of the facility who paid him back the $100.G. On 12/12/25 at 10:30 am, during interview with the administrator (ADM), she stated on 11/19/25 R #2 went to the transport clerk and told her he was trying to get ahold of the driver who he loaned $100 to. ADM stated R #2 gave a description and named the driver. ADM stated the clerk immediately told ADM. ADM stated she then called the transport dispatch center, who transports for Genesis facilities, to get information about the driver. ADM stated she conference called the driver who admitted to taking money from R #2 but stated it was given as a tip. ADM stated the driver was placed on administrative leave the same day. ADM stated all other drivers were interviewed and stated they knew not to accept money from residents. ADM stated all of the transport drivers were reeducated and completed Code of Conduct training. ADM stated audit was completed and facility interviewed other residents who utilized transportation, no other residents reported any issues. ADM stated the transport company terminated the driver and the facility reimbursed R #2 for the $100.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report a medication error involving 1 (R #1) of 1 (R #1) to the State Agency as required. This failure limited regulatory oversight and placed the residents at risk for serious harm by delaying external review and corrective action.If a facility fails to report medication errors in accordance with abuse prevention and reporting requirements, then the facility limits the State Agency's ability to ensure resident safety, increasing the risk of unaddressed harm and repeated incidents.The findings are:A. Record review of the facility's Abuse Prohibition Policy revised 11/14/25, revealed the facility prohibits abuse, mistreatment, neglect, exploitation, misappropriation of patient property, and injuries of unknown source and requires immediate reporting, investigation, and protection of patients. The policy specifies that allegations resulting in serious bodily injury must be reported immediately but no later than two (2) hours, and allegations not resulting in serious bodily injury must be reported within twenty-four (24) hours, with final investigation results reported within five (5) working daysB. Record review of R #1's Face Sheet revealed she was admitted on [DATE] with diagnoses including morbid obesity (severely overweight) and Type 2 diabetes mellitus (DM2, a disease in which the body cannot make or properly use insulin)C. Record review of the physician orders dated 08/01/25 showed an active order for Mounjaro (tirzepatide) 12.5 mg subcutaneous (under the skin) once weekly, and an active order for Emgality (migraine medication)120 mg/units per milliliter (u/ml) to be administered monthly for migraine prophylaxis.D. On 12/11/25 at 2:25 p.m., during an interview with the Administrator, she stated the facility did not report the medication error to the State Agency. The Administrator stated she was surprised no report had been submitted and identified that it would have been her expectation that an error of this magnitude be reported. She further stated the facility may not have reported the incident due to high staff turnover and operational challenges, including the Director of Nursing being on leave, the training of a new Director of Nursing, and ongoing staffing instability at the time of the incident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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 interviews, the facility failed to prevent a significant medication error when staff administered a second dose of Mounjaro (GLP-1 Trizepatide) 12.5 milligrams (mg) within 24 hours to 1 (R#1) of (R #1). The facility also failed to ensure accurate medication administration practices consistent with the resident's prescribed regimen. The Findings are: A. Record review of the facility's Medication Administration policy, dated January 2025, revealed licensed nurses must administer medications in accordance with the written orders of the prescriber.B. Record review of R #1's Face Sheet revealed she was admitted on [DATE] with diagnoses including morbid obesity (severely overweight) and Type 2 diabetes mellitus (DM2, a disease in which the body cannot make or properly use insulin)C. Record review of the physician orders dated 08/01/25 showed an active order for Mounjaro (tirzepatide) 12.5 mg subcutaneous (under the skin) once weekly, and an active order for Emgality (migraine medication)120 mg/units per milliliter (u/ml) to be administered monthly for migraine prophylaxis.D. Record review of the facility's Change in Condition (CIC) report dated 09/25/25 revealed staff administered Mounjaro to R #1 on 09/25/25 instead of the ordered Emgality injection. The CIC documented the resident had already received her scheduled weekly Mounjaro dose on 09/24/25, resulting in the resident receiving two doses of Mounjaro within 24 hours.E. Record review of R #1's progress notes dated 09/25/25, documented by the Nurse Practitioner (NP), revealed the NP contacted Poison Control regarding a duplicate medication dose. Poison Control advised the duplicate dose could cause nausea, vomiting, diarrhea, abdominal pain, abdominal distention, and hypoglycemia (low blood sugar) and recommended enhanced monitoring. The NP ordered the resident's glimepiride (an oral antidiabetic medication used to lower blood glucose levels) and Actos (pioglitazone-an oral antidiabetic medication used to improve insulin sensitivity and control blood sugar) to be held for five days and ordered blood glucose monitoring four times daily.F. Record review of R #1's September 2025, medication administration record (MAR) revealed staff continued routine blood sugar checks already in place for diabetes management but did not increase monitoring beyond the resident's baseline schedule.G. Record review showed no documentation the facility reassessed the resident for side effects, no nursing narrative assessing symptoms, and no monitoring beyond routine diabetic checks.H. On 12/11/25 at 1:35 p.m., during an interview with the Interim Director of Nursing (DON), she stated staff administered the wrong injection, giving Mounjaro instead of Emgality. She stated it is her expectation the resident would not of received two doses of Mounjaro, as this could of cause adverse reaction to the resident.I. On 12/11/25 at 2:25 p.m., during an interview with the Administrator, she stated the nurse immediately reported the error and she learned of the event during the Interdisciplinary Team (IDT; includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, resident or resident representative, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident) meeting on 09/26/25. She stated the monitoring consisted of routine blood sugar checks and observation for symptoms. She stated no symptoms were reported by staff.J. On 12/11/25 at 3:15 p.m., during an interview with the Medical Director, she stated a duplicate dose of Mounjaro requires monitoring for hypoglycemia (low blood sugar, normal blood sugar measurement is 70 to 99 mg/dL) and adverse symptoms. She stated the error met the criteria for a significant medication error and stated it should have been reported to the state.K. On 12/12/25 at 8:00 a.m., during an interview with RN #1 she stated the resident had a weekly injectable migraine medication and a weekly Mounjaro injection stored in the same refrigerator. She stated the medications looked exactly the same. She reported the electronic MAR continued prompting administration of Mounjaro, contributing to the error. After realizing the mistake, she stated she notified the resident, the nurse practitioner, the guardian, and the charge nurse. She stated Poison Control was contacted, and staff monitored the resident's blood sugars and symptoms.L. On 12/12/25 at 8:27 a.m., during an interview with Charge Nurse, she stated she worked at the facility during the time R #1 received a duplicate dose of Mounjaro. She stated the resident was scheduled to receive a weekly injectable migraine medication but was administered Mounjaro instead. The Charge Nurse stated the medication error was related to the nurse that admistered the medication not reading the medication label carefully.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored securely when a medication cart remained unlocked and unattended on the 200 Hall. This failure created the potential for unauthorized access to medications, including controlled substances, for 1 of 1 medication carts observed. The findings are: A. Record review of the facility's Medication Storage and Security Policy, revised January 2025, revealed the facility requires all medications to be kept secured at all times. The policy states medication carts must remain locked when not in the direct possession of licensed staff, and controlled substances must be stored in a separately locked, permanently affixed compartment. The policy further states staff must ensure medications are protected from unauthorized access by residents, visitors, or staff. B. On 12/12/25 at 9:17 a.m., observation of the 200 Hall revealed a medication cart positioned in the hallway with the top drawer unlocked. No staff were present in the immediate area, and the cart remained unattended and accessible to residents walking through the hallway.C. On 12/12/25 at 9:18 a.m., during an interview, RN #5 stated she had just stepped away for a moment into a resident's room and confirmed she left the cart unlocked. RN #5 stated the cart contained narcotics stored inside the locked box, but the remaining drawers contained other resident medications. RN #5 stated, If the medication cart is left unlocked a resident could get into the cart and take medication that does not belong to them.D. On 12/12/25 at 3:32 p. m., during an interview with interim DON, she stated it is her expectation all medications carts should remained locked at all times. She stated if the medication carts are not locked then a resident could go into the medication cart and take medication that does not belong to them.