

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2025
NAME OF PROVIDER OR SUPPLIER  Uptown Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7900 Constitution Avenue NE Albuquerque, NM 87110	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation and interviews, the facility failed to close or lock the computer screen on the medication cart making personal information inaccessible to unauthorized staff and other residents for 1 (R #18) of 1 (R #18). This deficient practice could cause other to view sensitive, private, medical information. The findings are: A. On 07/29/25 at 1:05 pm, an observation was made of Nurse #9 walking away from the medication cart without locking the computer screen. Nurse #9 was observed to walk into a resident's room. Other (unidentified resident and staff members) were also present on the hall. The computer screen was open with medical information for an unidentified resident up on the screen. B. On 07/29/25 at 1:08 pm, an observation was made of the Unit Manager (UM) #2 walking down the hall. UM stopped at the medication cart and closed the screen to the computer. She was observed telling Nurse #9, he needed to close or lock the screen on the medication cart every time he walks away from it. C. On 07/29/25 at 1:08 pm, during an interview with the UM #2 she stated the expectation is to close or lock the computer screen on the medication cart every time a nurse walks away from it. UM #2 stated Nurse #9 was new and he is still being trained. D. On 07/30/25 at 2:04 pm, during an interview with the Administrator, she confirmed the computer screen should not have been open with resident medical information for others to see it.</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 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>Based on record review and interview, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice by not following physician orders for 1 (R #15) of 1 (R #15) resident reviewed for diabetic medications. Failure to follow physician orders is likely to cause residents to not receive the care and treatment they require. The findings are: A. Record review of R #15 face sheet revealed an admission date of 05/26/24. R #15 had a diagnosis of: -Chronic Obstructive Pulmonary Disorder (COPD; lung disease). -Type II diabetes (DM2, a disease in which the body cannot make or properly use insulin). -Hodgkin lymphoma (type of cancer that affects the lymphatic system) -Asthma (chronic lung disease). -Cardiomegaly (a medical condition in which the heart becomes enlarged). B. Record review of R #15's physician orders revealed the following orders: -Insulin Glargine Subcutaneous (fat layer between skin and muscle) Solution Pen-injector 100 UNIT/milliliter. Inject 18 unit subcutaneously one time a day for Diabetes Mellitus type 2. Decrease 20 units to 18 units start date 05/08/25. -Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject 29 unit subcutaneously one time a day for DM2. Increase AM from 20 units to 25 units to 27 units to 29 units start date 03/23/25. -Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject 29 unit subcutaneously one time a day for DM2. Start date 03/24/25. -Hypoglycemia (blood sugar is too low) Protocol (fast acting carbohydrates released into the system) Observe Sign /Symptoms of hypoglycemia as needed If blood glucose is less than 70 mg/dl or ordered low parameter follow Hypoglycemia protocol start date 05/27/24 -Glucagon (peptide hormone) Emergency Kit 1 MG Glucagon Inject 1 mg intramuscularly (into the muscle) as needed for blood glucose (BG) less than 70. Not arousable conscious or able to swallow Hold all diabetic meds until provider authorizes resumption, remain with patient and keep in bed/chair for safety. Repeat blood glucose in 15 min. Start date 05/27/24 C. Record review of R #15's care plan, dated 05/27/24, revealed the following: - Problem: Diabetes. - Focus: R #2 should be free of all signs and symptoms of hyper/hypoglycemia (low blood sugar, normal blood sugar measurement is 70 to 99 mg/dL), - Intervention: Monitor for signs and symptoms of hyper/hypoglycemia and report abnormal findings to physician. D. Record review of R #15's blood glucose readings, dated 05/01/25 through 05/18/25 revealed staff documented the following: - On 05/18/25 at 6:23 am, R #15's blood glucose measured 67.0 mg/dL. - On 05/17/25 at 9:26 am, R #15's blood glucose measured 61.0 mg/dL. - On 05/11/25 at 8:51 am, R #15's blood glucose measured 62.0 mg/dL. -On 05/07/25 at 7:32 am, R #15's blood glucose measured 50.0 mg/dL. -On 05/04/25 at 6:30 am, R #15's blood glucose measured 67.0 mg/dL. E. Record review of R #15's medication administration record (MAR), dated 05/01/25 through 05/18/25, revealed staff did not administer the Insta-Glucose as ordered by the physician when R #15's blood glucose measured below 70. F. On 07/30/25 at 1:30 pm, during an interview with the Director of Nursing (DON), she stated R #15 had an order for Insta-Glucose if his blood sugar measured below 70 mg/dL. She stated she expected staff to administer the Insta-Glucose gel if R #2's blood sugar dropped below 70. G. On 07/30/25 at 2:04 pm, during an interview with the Administrator, she stated her expectation would be that nurses follow the orders. If his blood sugar falls below 70, nurses should give the insta glucose. H. On 07/30/25 at 10:20 am, during an interview with Nurse #9, she stated if a resident's blood sugar was below 70, then she would assess the resident and give them sugar like a cookie or candy or juice. She stated if the sugar did not work, then she would give the insta glucose. I. On 07/30/25 at 10:30 am, during an interview with Nurse #10, she stated if a diabetic resident had a blood sugar below 70, then you should follow the physician's order. She stated staff should check to see if the residents were alert and conscious and then give them insta glucose. Nurse #10 stated staff should not give juice first, and nurses should always follow the physician order. Nurse #10 stated if the resident refused the glucose gel, then she would give orange juice or milk.</p>		

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F 0695  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed.  (continued on next page)

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to follow physician orders when staff did not enter an order for a nebulizer (device that turns liquid medication into a fine mist, allowing it to be inhaled directly into the lungs) treatment into the medical record for 1 (R #15) of 1 (R #15) resident. This deficient practice could likely result in a resident not receiving the treatment as ordered by the physician which could cause the resident's respiratory status to be compromised. The findings are: A. Record review of R #15's face sheet revealed an admission date of 05/26/24 with the following diagnoses: -Chronic Obstructive Pulmonary Disorder (COPD; lung disease). -Type II diabetes (DM2; a disease in which the body cannot make or properly use insulin). -Hodgkin lymphoma (type of cancer that affects the lymphatic system) -Asthma (chronic lung disease). -Cardiomegaly (a medical condition in which the heart becomes enlarged). B. Record review of R #15's encounter notes, dated 05/17/25 at 1:00 am and written by telehealth provider after hours, revealed R #15 experienced hypoxia (a condition where tissues are deprived of adequate oxygen supply). The assessment and plan for exacerbation COPD: Give albuterol (aerosol medication that helps with breathing difficulties) nebulizer treatment now and attempt to decrease oxygen to 3 liters per minute (LPM) after nebulizer treatment. Notify provider if shortness of breath worsens, patient appears to be in distress or if oxygen saturation decreases. C. Record review of R #15's change in condition notes, dated 05/17/25 at 1:06 pm, revealed R #15 experienced shortness of breath and his oxygen saturation was at 85 percent (%). The provider recommended to give a nebulizer treatment and decrease oxygen from 5 LPM to 2 LPM for COPD and anxiety. D. Record review of R #15's encounter notes made by telehealth providers after hours, dated 05/17/25 at 9:00 pm, indicated R #15 experienced an episode of COPD exacerbation and anxiety attack and was treated for both. R #15 experienced new onset confusion, and the patient was seen grabbing at things that were not there. R #15's oxygen was 92%, and the resident was currently on 5 LPM by nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). The resident denied shortness of breath. RN reported the daughter was present in the room and requested transportation to hospital for further work up. The resident's oxygen (O2) was 92% on 5 LPM per nasal cannula. The provider sent R #15 out to the hospital. E. Record review of R #15's physician's orders, dated 05/17/25, revealed staff did not enter the albuterol nebulizer treatment order into the medical record. F. Record review of R #15's progress notes, dated 05/17/25, revealed staff did not document R #15 received the nebulizer treatment. G. Record review of R #15's nursing progress notes revealed the following: - Dated 05/18/25 at 6:13 am, R #15 had a quiet night but had one episode of panic attack and yelling that he wants to be released. The resident's oxygen saturation remained low on 2 LPM ranging between 79% to 88%. - Dated 05/18/25 at 1:41 pm, R #15 expressed being ready to go (die) and was experiencing delirium by grasping at things in the air and asked staff to take the animals out of his room and to kill the birds on his bed. Oxygen level 1 to 4 LPM was 88-89%, increased to 5 LPM. The resident's oxygen saturation went up to 92%. - Dated 05/18/25 at 2:29 pm, R #15 was transferred to the hospital. H. On 07/30/25 at 10:51 am, during an interview with the Market Resource Clinician (MRC) and the Director of Nursing (DON), the MRC stated she saw where the nebulizer treatment was the plan for R #15 on two different occasions on 05/17/25 by two different after-hours providers. The MRC stated she did not see either of the nebulizer treatments in the physician orders, and it was not clear if R #15 received the nebulizer treatments. The MRC stated since there was not a lot of documentation in the resident's record, and it was not clear what happened. The MRC did not know if the resident's oxygen LPM was raised from 2 LPM when R #15's oxygen saturation was between 77 to 88%. The MRC stated the nurses might have give R #15 the treatment without putting the order in for it. She stated that was not what should happen, but it could have. I. On 07/30/25 at 2:04 pm, during an interview with the Administrator, she stated it was expected for staff to put orders for any treatment or medication into the residents' medical record. The Administrator stated there had been some issues with the on-call provider in the past. She stated the on-call providers have not always communicated the orders verbally, and they just put them into their encounter note. The Administrator stated the nurse would be unaware of the order if that occurred.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations and interviews, the facility failed to secure medications and make them inaccessible to unauthorized staff for one medication cart on the 300 hall, creating a risk of unauthorized staff or residents taking a medication not prescribed to them. This deficient practice had the potential to affect all 25 residents residing on 300 hall as identified by the Resident Census provided by the Administrator on 07/29/25.A. On 07/29/25 at 1:05 pm, an observation was made of Nurse #9 walking away from the medication cart without locking it. Nurse #9 was observed to walk into a resident's room. Other (unidentified resident and staff members) were also present on the hall.B. On 07/29/25 at 1:08 pm, an observation was made of the Unit Manager (UM) #2 walking down the hall. UM stopped at the medication cart and locked it. She was observed telling Nurse #9 he needed to lock the medication cart every time he walks away from it. C. On 07/29/25 at 1:08 pm, during an interview with the UM #2 she stated the expectation is to lock the medication cart every time a nurse walks away from it. UM #2 stated Nurse #9 was new and he is still being trained. D. On 07/30/25 at 2:04 pm, during an interview with the Administrator, she confirmed the cart should not have been left unattended.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to prepare and serve food under sanitary conditions when dietary staff failed to wear hairnets while in the kitchen. This deficient practice is likely to affect all 120 residents listed on the resident census list provided by the Administrator (ADM) on 07/29/25 and are likely lead to foodborne illnesses in residents if food is not being prepared and safe food handling practices are not adhered to. The findings are: A. On 07/29/25 at 8:04 am, observation revealed [NAME] prepared and served food in the kitchen and did not wear a hair net. B. On 07/29/25 at 8:30 am, observation revealed Kitchen Account Manager (KAM) walked in the kitchen and did not wear a hair net. C. On 07/29/25 at 8:19 am, during an interview with the Cook, she confirmed she was not wearing a hairnet when preparing and serving resident meals. She stated she should be wearing a hairnet while working in the kitchen. D. On 07/29/25 at 8:39 am, during an interview with the KAM, she stated all kitchen staff including herself should be wearing hair nets when entering and working in the kitchen. E. On 07/30/25 at 2:11 pm, during an interview with the ADM, stated all staff, not just kitchen staff, should wear a hair net when entering the kitchen and going past the marked yellow line. She stated kitchen staff should be wearing hair nets at all time while working in the kitchen.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on record review, observation, and interviews, the facility failed to maintain an effective pest control program (measures to eradicate and contain common household pests) so that the facility is free of pests and rodents. This deficient practice is likely to affect all 120 residents listed on the resident census list provided by the Administrator (ADM) on 07/29/25 and are likely lead to airborne illnesses, emotional distress, and may deteriorate quality of life in residents. The findings are: A. Record review of the facility's Infection Control Practices policy, dated 01/08/24, revealed the following:- All tasks will be documented in the TELS (a building management platform that helps maintenance staff with facility maintenance, life safety code inspection and testing, and asset management) Preventive Maintenance program.- The facility will provide a pest free environment by contracting a pest control vendor for appropriate services on a periodic basis whether weekly, monthly, or as needed. B. Record review of the facility's monthly resident council minutes revealed the following:- On 06/19/25, noted complaints to administration stating the residents are seeing big roaches alive and coming up from the drains. There were also noted concerns of mice being spotted at night in the backyard.- On 07/17/25, noted reports of mice in residents' room and requests for more fly traps in the kitchen. There were also noted reports of cockroaches in a resident's peanut butter and jelly sandwich, cockroach in the food tray on 100 hall, and flies on cottage cheese cups. C. Record review of the facility's grievance form, dated 07/02/25, revealed R #7 witness a cockroach in the food cart on 100 hall, it was crawling around and on the food trays. D. Record review of the [Name of Exterminators Corporation] Invoices revealed the following:- On 05/27/25, a contractor sprayed inside of common areas and all interior parts of the building. Invoice noted few roaches noted at the end of the halls by exit doors. A contractor requested respray since he is still seeing roaches in the building. Invoice noted the targeted pest were ants and roaches.- On 06/27/25, a contractor sprayed inside of common areas and all interior parts of the building. Invoice noted kitchen was good and clean, but a few roaches were still noted in the kitchen. Invoice noted plastic wall covering needed to be replaced due to it separating from the wall and roaches are nesting behind the paneling. Invoice noted the targeted pest were ants and roaches.- On 07/25/25, a contractor sprayed inside of common areas and all interior parts of the building. Invoice noted kitchen was good and clean, but a few roaches were still noted in the kitchen. Invoice noted the targeted pest were ants and roaches. E. Record review of the facility's TELS work orders revealed the following:- On 05/23/25, spiders reported in the residents' rooms.- On 06/13/25, cockroaches reported on multiple walls and on food trays.- On 07/14/25, mice reported in resident room. F. On 07/29/25 at 8:18 am, observation revealed three small insects characterized by one pair of wings and a pair of halteres (modified hind wings used for balance) flying and landing on top serving plates, serving side up, in the kitchen. G. On 07/30/25 at 2:54 pm, observation revealed a brown oval-shaped bug with two long antennae and six legs upside down and was still moving in the facility's conference room. H. On 07/29/25 at 8:49 am, during an interview, Kitchen Account Manager (KAM) stated her expectation is for the pest contractor to go and spray the kitchen for pest control when insects are seen in the kitchen. KAM stated when kitchen staff see flies they just shoosh them away and sanitize the area the flies were. She stated serving plates should be stored upside down, serving side down, but it is hard to do so as they are not steady to keep the plates upside down. I. On 07/29/25 at 1:06 pm, during an interview, R #8 stated she has seen roaches and spiders in her room and bathroom. J. On 07/29/25 at 1:23 pm, during an interview, R #7 stated she was given a peanut butter and jelly sandwich for lunch and when she took a bite, she noticed the taste was off. She stated she opened her sandwich and realized there was a cockroach in her sandwich that she had just taken a bit off. R #7 stated she told the Unit Manager (UM) about the incident the day it happened. R #7 stated she tried talking to the KAM the day of the incident but got denied and instead was offered meal alternatives from other kitchen staff. She stated she refused meal alternatives as she was disgusted by the food at that time. R #7 stated she witnessed a roach inside the food cart that had unserved food trays in 100 hall as well. She stated two Certified Nursing Assistants were screaming when they were at the food cart, that caught her attention and got closer to realize there was a roach inside the food cart. K. On 07/29/25 at 2:13 pm, during an interview, Unit Manager (UM) stated a resident did notify her of a roach being in the resident's lunch and resident had taken a bite of the sandwich with the roach inside of it. UM stated she has seen a roach before in the food carts and notified the Administrator (ADM) and Director Of Nursing (DON) at that time. She stated another resident had a mouse inside their room and witnessed a hole in the wall. LIM stated Maintenance Director (MD) was notified</p>		