Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325119	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Albuquerque	2701 Richmond Drive 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure staff completed and transmitted a discharge Minimum Data Set assessment (MDS; a federally mandated assessment instrument completed by facility staff) 14 days after discharge for 1 (R #39) of 1 (R #39) resident reviewed for MDS assessments. This failed practice could lead to the facility not reporting accurate information to the Centers for Medicare & Medicaid Services (CMS). The findings are: A. Record review of R #39's Face Sheet, undated, revealed the following: - An admission date of 11/14/24. - A discharge date of 12/13/24. B. Record review of R #39's Electronic Health Record (EHR) revealed the following: - The MDS Licensed Practical Nurse (LPN) completed R #39's admission MDS, dated [DATE]. - The MDS LPN did not initiate a discharge MDS. C. On 03/26/25 at 11:27 am, during an interview, the facility's MDS LPN stated she expected the previous MDS LPN, who does not work with them any longer, to complete R #39's discharge MDS. She stated the Director of Nursing (DON)/Registered Nurse (RN) Assessment Coordinator should sign off on the discharge MDS to verify completion within 14 days of R #39's discharge. She stated R #39's discharge MDS should have been completed and transmitted 14 days after discharge. D. On 03/26/25 at 11:35 am, during an interview, the Director of Nursing (DON)/Registered Nurse (RN) Assessment Coordinator stated she expected the previous MDS LPN to complete R #39's discharge MDS. She stated she should have verified the discharge MDS was completed, but she forgot to review the discharge MDS.

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation and interview, the facility failed to ensure 1 (R #9) of 1 (R #9) resident received a meal at lunch time. This deficient practice could likely cause hunger and weight loss. The findings are: A. On 03/24/25 at 1:00 pm, during observation and interview, staff finished lunch service to the north hall, and the residents ate their lunch. Residents on the north hall were finishing their lunch meals. Further observation revealed R #9 did not have a meal tray on her table. R #9 stated she did not eat lunch yet, because staff did not bring her a meal tray. She stated she would like to eat lunch, because she was hungry. B. On 03/24/25 at 1:05 pm, during an interview with Certified Nursing Assistant (CNA) #6, she stated she thought R #9's tray was on the food cart, but she did not find it on there. She stated she could not find a meal refusal by R #9. C. On 03/24/25 at 1:12 pm, during an observation and interview, CNA #6 brought a lunch meal tray for R #9. CNA #6 stated the kitchen staff stated R #9 marked her meal ticket as she did not want a lunch tray. D. On 03/27/25 at 10:23 am, during an interview with the Kitchen Manager (KM), she stated it was expected for staff to check with the resident if a meal ticket was marked that the resident did not want a meal. E. On 03/27/25 at 12:08 pm, during an interview with Director of Nursing (DON), she stated if a meal ticket came into the kitchen and indicated a resident wanted to skip any meal, then the CNAs should check with residents on whether they wanted a meal. She stated if the resident refused the meal, then staff would not ask the resident again. The DON stated she was not aware there was an issue with a resident's meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food under sanitary conditions when staff failed to: 1. Label and date all items in the kitchen refrigerator. 2. Cover foods in the refrigerator and the storage room . 3. Remove dented, expired can of olives from the ready-to-use rack. 4. Wear hairnets and beard guards in a manner to cover all their hair while in the kitchen. These deficient practices are likely to affect all residents listed on the resident census provided by the Administrator on 03/27/25. Failure to store food under safe and sanitary conditions could likely to lead to foodborne illnesses in residents. The findings are: Food Storage A. On 03/24/25 at 7:45 am, during an initial walk through the kitchen, observation revealed the following: In the dry storage room: -A large, uncovered plastic container of sliced almonds. -A dented can of sliced ripe olives, expired 12/29/23. -A sweet potato was cut in half, not covered, and very dried out. In the refrigerator and freezer: -Meatballs were not in a sealed container and frost bitten. -A bag of corn and a bag of peas were not sealed. -A tray of deserts was not covered and was undated. -Sliced cheese was not covered and was hard and discolored. -A container labeled gluten was expired with a date of 03/15/25. -A container of BBQ sauce expired on 03/24/25. -Two containers of beans expired on 03/24/25 and on 03/14/25. -Packaged deli turkey expired 03/22/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Packaged deli ham expired 03/23/25. -A package of flour tortillas was open and undated. - A container of pudding expired on 03/22/25. -A container of pumpkin filling expired on 03/22/25. - A large pitcher of orange juice undated. -A container of tomato juice undated. B. On 03/24/25 at 8:00 am and 03/26/25 at 2:30 pm, during an interview with the Kitchen Manager (KM), she stated there should not be any uncovered food, expired food in the storage room, the refrigerator, and the freezer. She stated staff should have removed the dented can from the shelf of foods to use. The KM also stated the sweet potato should not have been cut in half and thrown back in the box with the other sweet potatoes. She stated the container of almonds should have a lid. She stated every person who worked in the kitchen was responsible to remove the expired food and make sure the food was covered. She stated every Friday kitchen staff checked the walk-in refrigerator for expired and undated food. Hairnets C. On 03/25/25 at 8:40 am, during observation of the kitchen, staff prepared breakfast plates for the residents. Further observation revealed the [NAME] wore a hairnet, but it did not cover all of the hair on his head. The [NAME] had facial hair which measured greater than 1/4 inch (in) and wore a beard guard. The beard guard did not cover all of the Cook's facial hair. Additional observation revealed an unidentified staff stood in a kitchen and wore a hat. The unidentified staff had a goatee which measured greater than 1/4 in., but he did not wear a beard guard. D. On 03/26/25 at 11:35 am, during an interview, the Administrator stated staff should wear hairnets and beard guards anytime they are in the kitchen, and the hairnets and beard guards should cover all the staff's hair. E. On 03/26/25 at 11:40 am, during an observation of the kitchen, staff prepared breakfast plates for the residents. Further observation revealed the [NAME] wore a hairnet, but it did not cover all of the hair on his head. The [NAME] had facial hair which measured greater than 1/4 inch (in) and wore a beard guard. The beard guard did not cover the all the Cook's facial hair. F. On 03/27/25 at 9:10 am, during observation of the kitchen, the [NAME] stood near the stove and food preparation tables. Further observation revealed the [NAME] wore a hairnet, but it did not cover all of the hair on his head. The [NAME] had facial hair which measured greater than 1/4 inch (in) and wore a beard guard. The beard guard did not cover the all the Cook's facial hair.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to keep the facility's eye washing stations (EWS, units for washing off chemicals or substances that might have splashed into an individual's eyes before they can seek further medical attention) free from dust, debris, and other microscopic organisms from contaminating the water outlets when staff failed to maintain the protective caps on the spray heads for 2 (EWS #1, EWS #2) of 2 (EWS #1, EWS #2) eye washing stations. This deficient practice is likely to lead to staff being exposed to water that may contain contaminants such as rust, scale, chemicals buildup, and harmful microbes. The findings are: A. Record review of the EWS's manufacturer's guidelines, dated 2023, following: - Periodic cleaning of the eyewash aerators (screens at the end of a faucet. The revealed the devices reduce the amount of water that comes out of a faucet and controls the stream) is advisable to ensure proper water flow. - Keep plastic dust covers on spray heads when the unit is not in use. - The EWS unit, like all emergency eyewash and shower equipment, should be tested weekly. B. Record review of the facility's Eye Wash Policy, undated, revealed the following: - Eye wash stations to be installed in areas where employees may be exposed to hazardous chemicals, cleaning agents, or other potentially harmful substance. - In the event of eye contamination, the affected individual will immediately proceed to the nearest eye wash station. - Keep eyes open and flush with water. - The policy did not state the required maintenance and periodic inspection for the EWSs, to include maintenance of the protective caps on the spray heads. C. On 03/26/25 at 12:57 pm, during an observation, the eye washing station, located on the dirty side of the laundry room, did not have a dust cover on the right spray heads. Further observation revealed the sink did not have any signs to instructing staff not to use the EWS or the location of an alternate EWS. The area also did not have any emergency eye wash bottles (a portable, self-contained unit designed to provide immediate flushing of the eyes in case of a chemical splash or other eye injury). D. On 03/27/25 at 8:55 am, during an interview, the Director of Nursing (DON) stated she expected staff to maintain dust covers on the EWSs spray heads. She stated staff should post a sign over the EWS instructing staff not to use the EWS if the station was not in working condition. She stated it was expected for emergency eye washing bottles to be available for use until the EWS was in working condition again. She stated staff could go to the second EWS, located in the kitchen, in case of exposure, or they could use the EWS in the laundry room. She stated she was not worried about a little dust in the spray heads in an emergency. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 03/27/25 at 9:00 am, during an observation, the eye washing station, located on the dirty side of the laundry room, did not have a dust cover on the right outlet head. The laundry technician actively washed dirty clothes and moved around the room near the EWS. Further observation revealed the sink did not have any signs to instructing staff not to use the EWS or the location of an alternate EWS. The area also did not have any emergency eye washing bottles (stand alone bottles of water to wash eyes in case of emergency.) Shelves of various cleaning chemicals were also located on the dirty side of the laundry room. F. On 03/27/25 at 9:02 am, during an interview, the laundry technician stated she worked at the facility as a laundry technician for the past six years. She stated she did not know when the EWS dust cover went missing. She stated she used detergents and other types of chemicals in her job duties. She stated if she needed to wash her eyes, then she would use the available EWS in the laundry room. She stated she did not know if there were any backup eye washing bottles to use. She stated she did not see a sign instructing staff not to use the EWS or the location of an alternate EWS. She stated she was not aware of the location of any other EWS in the facility. G. On 03/27/25 at 9:10 am, during observation, the facility's kitchen was located across the facility from the laundry room, down a hallway and through the lobby and main dining room. Further observation of the EWS located in the kitchen revealed the following: - The eye wash station was located adjacent to the stove. - The EWS contained two spray heads, and there were not dust covers on any of the spray heads. - Staff actively preparing meals around the unprotected water outlets. - The spray heads contained material buildup and yellowish, brown discoloration. - The sink did not have any signs to instructing staff not to use the EWS or the location of an alternate EWS - The area also did not have any emergency eye wash bottles H. On 03/27/25 at 9:14 am, during an interview, the Kitchen [NAME] and the Nutritional Services Director stated they worked at the facility in their positions for several years. They stated they did not recall when the dust covers on the eye washing spray heads went missing. They stated they would use the available unprotected eye washing station if they needed to rinse their eyes in case of an emergency. They stated they were not aware they should not use the unprotected eye wash outlets, and they did not know the location of any emergency eye washing bottle to use as a backup. I. On 03/26/25 at 12:58 pm and 03/27/25 at 10:12 am, during an interview, the facility's Administrator stated the eye washing stations should have caps on the outlet heads. He stated staff inspected and tested the eye wash stations monthly, and staff should report missing caps. He stated he expected staff to maintain dust covers on the outlet heads on EWSs.