STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiesta Park Wellness & Rehabilitation	8820 Horizon Boulevard NE Albuquerque, NM 87113

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete an initial skin assessment for 1 (R #1) of 3 (R #1, #2 and #3) residents reviewed for skin assessments, during the initial admission. If the facility fails to complete a skin assessments then facility is unable to provide proper care and treatment for the residents. The findings are: A. Record review of the State Agency complaint received on 05/13/25 stated that R #1 had been discharged AMA (against medical advice) from facility on 05/12/25 for physical abuse by facility staff and had been transported by [name of transport service] to [name of local hospital] at 6:00 pm with bruising, swollen genitals and penile bleeding along with various bruising on the body. B. Record review of R #1's facesheet revealed R #1 was admitted on [DATE]. C. On 05/14/25 at 11:17 am during a telephone interview with R #1's daughter, she stated that she believed her father was physically abused by the facility staff due to the amount of bruising present when she took R #1 out of the facility AMA (05/12/25). She further stated that R #1 had recently had a procedure at local hospital to have a de-fibulator implant (implanted to help monitor heart activity, delivers electrical shock to reset the heart to a normal rhythm) prior to admission to facility. Daughter stated that after taking her father home and seeing the extensive bruising she called an ambulance to transport R #1 to [name of local hospital] he was admitted and remains hospitalized (05/16/25). D. On 05/13/25 upon record review of R #1's medical chart a skin assessment was not available for review. E. On 05/15/25 at 10:57 am during an interview, the Director of Nursing (DON) stated that an initial skin assessments are completed upon admission by the admitting nurse, upon review of R #1's medical chart the DON did not observe that a skin assessment had been completed by the admitting nurse and should have been done. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. Building B. Wing	05/15/2025

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 05/15/25 at 2:43 pm during an interview with Licensed Practical Nurse (LPN) #1, he stated that he had not completed a skin assessment upon admission because the resident (R #1) was fatigued and extremely tired and he was attempting to complete paperwork with the family and the unit was very busy that night. LPN #1 further stated that he did not remove R #1's clothing to check his body for any bruising or surgical sites. LPN did notice that R #1 had tugged on his foley catheter (a thin flexible tube inserted into the bladder to drain urine) and the tip of the penis did have some excoriation (wearing away of the skin, resulting in a raw, irritated lesion). LPN #1 did not recall if he had let anyone know that he had not completed the skin check and he did not document any of his initial assessments as he should have, therefore it did not trigger on the system for another nurse to know that it had not been done. LPN #1 stated that he did not know reason for admission he had glanced at paperwork, but did not have time to read it extensively.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were updated with necessary documents and are accurate for 1 (R #4) of 1 (R #4) resident reviewed, when the facility failed to update and upload hospital discharge orders into the electronic medical record (EMR). This deficient practice is likely to result in residents not receiving accurate care and having an inaccurate medical record. The findings are: A. Record review of R #4's face sheet revealed she was admitted on [DATE]. B. On 05/14/25 at 10:23 AM, during an interview with R #4, she stated that intravenous (IV) antibiotics had been discontinued earlier than her hospital discharge orders indicated. She explained that the antibiotics should have continued for four weeks after her hospital discharge. C. On 05/15/25 at 10:28 AM, during an interview with the Nurse Practitioner (NP) #1, she stated that R #4 had been on IV antibiotics for a severe infection. She noted that R #4's hospital discharge orders dated 03/25/25 clearly stated that the IV antibiotics should continue until 04/25/25. She further explained that the facility had discontinued the antibiotics on 04/01/25 and did not restart them until she re-ordered them on 04/11/25. D. On 05/15/25 at 1:24 PM, during an interview with Licensed Practical Nurse (LPN) #2, he stated that he had received incomplete hospital discharge orders for R #4's admission. He explained that the orders for the IV antibiotics were not included in the discharge orders he had been given. LPN #2 further stated that he contacted the facility liaison to obtain updated discharge orders orders for R #4. He was emailed the updated discharge orders for R #4 on 03/25/25 which were then used for R #4's admission. The discharge orders were reviewed with NP #2 and entered into the EMR with. E. Record review of R #4's EMR revealed discharge orders dated 03/20/25. No updated discharge orders were available for state agency's review. F. On 05/15/25 at 2:25 PM, during an interview, the Director of Nursing stated that the discharge documents uploaded into the EMR were the original discharge orders sent by the hospital case manager. She further explained that, after researching and reviewing the message thread between the admissions nurse and facility liaisons, it was revealed that updated discharge orders had been emailed directly to LPN #2, the admitting nurse for R #4. LPN #2 was able to provide the updated orders to the Director of Nursing, who stated that they should have been uploaded into R #4's EMR but were not.