STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325126	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Estancias by Pure Health	3620 Las Estancias Dr SW Albuquerque, NM 87121

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR; a screening to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment was accurate for 1 (R #3) of 4 (R #3, R #8, R #37, and R #112) residents reviewed for PASRR accuracy. This deficient practice is likely to result in the residents not receiving the services they need. The findings are: A. Record review of R #3's admission Record revealed R #3 was admitted into the facility on [DATE] with multiple diagnoses including: 1. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 2. Unspecified psychosis (mental disorder) not due to a substance or known condition, 3. Schizoaffective disorder (a mental condition that causes both psychosis and mood problems), 4. Other specified anxiety (feelings of fear or apprehension) disorder, 5. Delusional disorders (condition in which a person can't tell what's real from imagined), 6. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). B. Record review of R #3's PASRR, dated 11/06/15, revealed staff documented R #3 does not have a diagnosis or suspected mental illness. C. On 02/21/25 at 2:11 pm, during an interview with the [NAME] President of Clinical Services,she confirmed R #3's PASRR was not correct.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, person-centered comprehensive care plan for 4 (R #4, R #72, R #109, and R #164) of 9 (R #3, R #4, R #8, R #37, R #46, R #62, R #72, R #109 and R #164) residents reviewed for care plans. This deficient practice is likely to result in staff being unaware of the current and actual needs of the residents. The findings are: R #4 A. Record review of R #4's face sheet revealed R #4 was admitted to the facility on [DATE] with the following diagnoses: 1. Acute osteomyelitis (a bone infection that develops rapidly and is characterized by inflammation and destruction of bone tissue), right ankle and foot, 2. Abnormalities of gait and mobility (a deviation from the normal pattern of walking), 3. Lack of coordination, 4. Chronic pain syndrome (a condition characterized by persistent pain that lasts for at least three months and significantly impacts daily life), 5. Muscle wasting and atrophy (a condition where muscles lose mass and strength), 6. Age-related physical debility (a gradual decline in physical function and overall health that occurs with advancing age), 7. Acquired absence (the loss of a limb, organ, or body part due to injury, disease, or surgery) of right leg below knee, 8. Rheumatoid arthritis (a chronic inflammatory autoimmune disease that primarily affects the joints). B. Record review of R #4's bed rail assessment dated [DATE] revealed the following: 1. R #4 consented to bed rails for safety and comfort. 2. Bilateral (horizontal metal bars that attach to the side of a bed, extending a quarter of the length of the bed) rails indicated to serve as an enabler for independence. C. Record review of R #4's care plan dated 6/22/24 revealed there was not a care plan for bed rail use. D. On 02/18/25 at 11:21 am during an observation of R #4's bed revealed quarter side rails on each side of the bed. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 02/18/25 at 11:33 am during an interview, R #4 stated she was aware she had bed rails on each side of the bed and used the rails to help with repositioning herself and bed mobility. F. On 02/21/25 at 12:16 pm during an interview with the DON, she stated R #4 did not have a care plan for bed rails and should have. R #72 G. Record review of R #72's face sheet revealed R #72 was admitted to the facility on [DATE] with the following multiple diagnoses: 1. Muscle wasting and atrophy (a condition where muscles lose mass and strength), 2. Abnormalities of gait and mobility (a deviation from the normal pattern of walking), 3. Muscle weakness, 4. Pain in left hip, 5. Pain in right knee, 6. Lack of coordination. 7. Age-related osteoporosis (a condition that weakens bones and increases the risk of fractures) H. Record review of R #72's bed rail assessment dated [DATE] revealed the following: 1. R #4 consented to bed rails for safety and comfort. 2. Bilateral (having or relating to two sides) rails indicated to serve as an enabler for independence. I. Record review of R #72's care plan dated 07/15/24 revealed there was not a care plan for bed rail use. J. On 02/18/25 at 11:03 AM, during an observation of R #72's bed revealed quarter side rails on each side of the bed. K. On 02/18/25 at 11:03 AM during an interview, R #72 stated she was aware she had bed rails on each side of the bed to help reposition herself and bed mobility. L. On 02/21/25 at 12:16 pm during an interview with the DON, she stated R #4 did not have a care plan for bed rails and should have. R #109 M. Record review of R #109's face sheet revealed R #109 was admitted to the facility on [DATE] with the following diagnoses: (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Malignant neoplasm of the tongue (cancer of the tongue), 2. Unspecified; dysphagia (difficulty swallowing), 3. Unspecified; otitis media (inflammation of the ear), 4. Other lack of coordination (poor muscle control); 5. Dehydration (lack of total body water); 6. Malignant neoplasm of the head, neck and face (cancer that has spread to the neck, head and face); 7. Cognitive communication deficit (brain's inability to communicate effectively). N. Record review of R #109's care plan dated 02/07/25, revealed the antibiotic was not care planned. O. Record review of the Minimum Data Set (MDS) dated [DATE] (Entry MDS) shows the antibiotic was a hospital physician's order upon admission to the facility. P. Record review of R #109's progress note dated 02/07/25 at 3:20 pm, revealed the antibiotic was entered on the electronic medical record (EMR) for his admission. The antibiotic did not have a stop date. Q. On 02/21/25 at 12:55 PM, during an interview, the DON confirmed R #109's care plan did not contain any documentation of antibiotics. DON stated her expectations are the care plan would include all aspect of antibiotic management and monitoring. R #164 R. Record review of R #164's face sheet revealed R #164 was admitted to the facility on [DATE] with the following diagnoses: 1. Fracture of sacrum (a break in the sacrum bone, located at the base of the spine and forming the back wall of the pelvis), 2. Abnormalities of gait (a person's manner of walking) and mobility (a deviation from the normal pattern of walking), 3. Lack of coordination, 4. Polyosteoarthritis (a condition where multiple joints experience osteoarthritis, a form of degenerative joint disease), 5. Spinal stenosis (a condition where the spinal canal, the space within the spine that houses the spinal cord and nerve roots, becomes narrowed), cervical (neck) region. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S. Record review of R #164's bed rail assessment dated [DATE] revealed the following: 1. R #164 consented to bed rails for safety and comfort. 2. Bilateral rails indicated to serve as an enabler for independence. T. Record review of R #164's care plan dated 02/13/25, revealed there was not a care plan for bed rail use. U. On 02/18/25 at 1:27 PM, during an observation of R #164's bed revealed quarter sized rails on each side of the bed. V. On 02/18/25 at 1:27 PM, during an interview, R #164 stated she was aware she had bed rails on each side of the bed and used them for bed mobility. W. On 02/21/25 at 12:16 PM, during an interview with the DON, she stated R #164 did not have a care plan for bed rails and should have.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record reviews and interviews, the facility failed to ensure staff revised the care plan for 1 (R # 21) of 1 (R # 21) resident reviewed when staff failed to: 1. Update R 21's plan of care to include fall prevention and interventions. 2. Update R #21's plan of care to include oxygen therapy. 3. Update R #21's plan of care to include vision loss under ADL (activities of daily living) self-care performance deficit. This deficient practice is likely to result in staff not being aware of residents' care needs and preferences, and residents not receiving the needed care. The findings are: A. Record review of R #21's admission Record revealed R #21 was admitted to the facility on [DATE] with the following multiple diagnoses: 1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar) with diabetic chronic kidney disease (CKD; impaired kidney function), and polyneuropathy (a type of neuropathy (general diseases or malfunctions of the nerves) that affects many peripheral nerves in the body), 2. End Stage Renal Disease (ESRD; chronic irreversible kidney failure), 3. Major Depressive Disorder, a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 4. History of falling, 5. Osteoporosis without current pathological fracture (bones become extremely porous and are subject to fracture and slow healing). B. Record review of R #21's care plan dated 08/10/23 revealed the following: 1. Focus are of The resident is at risk for falls AEB (as evidenced by) actual falls. 2. Follow facility fall protocol. R #21's care plan does not list specific interventions that are in place to assist R #21 with his fall risk. C. Record review of R #21's medical orders revealed an order dated 01/14/25 for continuous oxygen at two liters per nasal canula (a small, flexible tube that delivers oxygen to the nose through soft prongs). D. Record review of R #21's care plan dated 11/07/23 revealed R #21 has as needed (PRN) order for oxygen therapy that is not consistent with current order for continuous oxygen therapy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Record review of R #21's progress note dated 01/09/25, revealed R #21 had acute vision loss after dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) and was sent to emergency room for evaluation. F. Record review of R #21's care plan dated 08/10/23, revealed R #24 had an ADL (activities of daily living) self-care performance deficit. This care plan did not include interventions to assist R #21 with his recent vision loss. G. On 02/21/25 at 11:15 AM, during an interview with the DON, she confirmed R #21's care plan was not accurately revised because of the following: 1. The DON was not able to produce a facility fall protocol and stated there was not individualized fall protocol for R #21 [fall protocol is listed on care plan but does not include what fall protocol include. Example: wear non-skid socks, non-skid shoes, fall mat etc]. 2. R #21's care plan for the use of oxygen does not match with R #21's current order for the continuous use of oxygen. 3. R #21's care plan for ADL self-care performance deficit and impaired visual function do not include specific interventions that R #21 needs to deal with his recent visual impairment.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to adequately monitor for the stop on the antibiotic for 1 (R #109) of 1 (R #109) resident reviewed for stop date on an antibiotic. This deficient practice could likely lead to overuse of an antibiotic and lead to multi-drug-resistant infections, antibiotic resistance and poor patient outcomes. The findings are: A. Record review of the facility's resident dashboard (an overview of the electronic health record) dated 02/07/25 revealed R #109 was admitted on this date. admission diagnosis includes, malignant neoplasm of the tongue (cancer of the tongue), unspecified; dysphagia (difficulty swallowing), unspecified; otitis media (inflammation of the ear) of the ear; other lack of coordination (poor muscle control); dehydration (lack of total body water); malignant neoplasm of the head, neck and face (cancer that has spread to the neck, head and face); and cognitive communication deficit (brain's inability to communicate effectively). B. Record review of R #109's Progress Note dated 02/18/25 at 11:33 am, revealed the physicians order for Ofloxacin otic solution 0.3% instill 5 drops in the right ear one time a day for ear infection, was to be continued. There was no stop date given for the antibiotic physician's order. C. Record review of R #109's history and physical dated 02/19/25, revealed the order to continue antibiotic and does not have a recommended stop date. D. On 02/21/25 at 12:55 pm, during an interview, the DON confirmed there was no care plan for the use of an antibiotic. The DON's expectations were that the care plan would include the reason for the antibiotic use, the start and stop dates, and all interventions to help prevent infection (harmful bacteria entering the body). E. Record review of R #109's progress notes from the Medical Director (MD) dated 02/18/25 at 11:33 am, revealed the antibiotic was given for otitis media (inflammation of the ear) and the physician was not sure if the infection was related to his cancer diagnosis. According to policy and procedure for antibiotic stewardship, all antibiotics require a stop and require reassessment. F. On 02/19/25 at 1:00 pm, during an interview, the DON stated according to the policy and procedure for antibiotic stewardship, all antibiotics must have a stop date and be reassessed for any changes. The DON would have expected the nurse to ask the Certified Nurse Practitioner (CNP) for a stop date. The DON stated the administration team completes a review of all antibiotics during the morning clinical meeting and they must have overlooked there was no stop date.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, record review, and observation, the facility failed to ensure staff served meals that were attractive and palatable (pleasant to taste) for 8 (R #'s 4, 12, 37, 46, 99, 105, 108, and 165) of 10(R #'s 4, 8, 12, 37, 46, 48, 99, 105, 108, and 165) residents reviewed for meal quality. This deficient practice reduces residents' ability to eat and enjoy meals, may decrease their quality of life, and could likely lose weight. The findings are: A. On 02/17/25 at 11:17 am, during an interview, R #108 stated the food does not taste good, it is overcooked. R #108 stated that the food is not palatable. R #108 stated that they are not getting vegetables very often either and when they do they are usually overcooked. B. On 02/17/25 at 11:22 am, during an interview, R #46 stated the food is not hot, always cold, is poor quality of food, not abiding by national diets. Every time they change managers the food gets worse. There have been three managers in three years. C. On 02/17/25 at 11:55 am, during lunch observation, residents were served shredded pork roast, oven fried potatoes, yellow squash medley, a wheat dinner roll, an iced brownie and a drink for lunch. The food was served to residents on an dinnerware that was the same neutral coloring as the food. The food was not appealing to the eye and lacked color. D. On 02/17/25 at 12:43 pm, during an interview, R #12 stated the eggs are tough and we had pasta yesterday with one big noodle and a bowl of peas. R #12 also stated for breakfast I had biscuits and gravy and I was not quite sure what it was until I poked it. E. On 02/18/25 at 11:21 am during an interview, R #4 she stated the food is not very good. F. On 02/18/25 at 11:49 am during an interview, R #99 stated the food is horrible, it is not like home cooking at all and lacks flavor. G. On 02/18/25 at 11:55 am, during a lunch observation, staff asked R #99 if she was going to eat lunch, R #99 declined to got to lunch. Staff then asked R #99 if someone was bringing her food as usual which R #99 replied a friend is bringing her food. H. On 02/18/25 at 12:34 pm during an interview, R #165 stated the food is awful, the food does not have any flavor, and the potatoes are really dry. R #165 also stated the food does not look good most days. I. On 02/18/25 at 2:33 pm, during an interview, R #105 stated she doesn't like the food it doesn't taste good and doesn't eat it very often. J. On 02/18/25 at 3:08 pm, during an interview, R #37 stated he does not like the food, the food is horrible. He stated he has food delivered to facility and keeps his own butter and cinnamon for his toast in his room. He stated the food has no flavor. K. Record review of the facility's policies and procedures for Dietary Management revised July 2017 under Assistance with Meals revealed Hot foods shall be held at a temperature of 136 degrees or above until served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. Record review of Resident Council minutes revealed the following: 1. On 09/06/24 dietary was requested to attend the next meeting due to food concerns. 2. On 10/04/24 residents talked about what they like to eat and what food they want. 3. On 11/01/24 residents complained about cold food being cold. The concern form was filled out and given to the DON to discuss with dietary staff. 4. On 02/07/25 residents complained about cold food and being unappetizing; food is always the same and does not taste good; same food all the time, always chicken and pork. Concern form filled out and given to dietary. M. On 02/21/25 at 9:38 am during an interview, the Culinary Supervisor (CS) confirmed the prepared menu offers a lot of foods that lack color and appeal. He stated he will ask residents about food choices when there is a complaint, otherwise he will make changes to meals for the residents when they arrive in the dining area on an as needed basis.

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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 and serve food under sanitary conditions when staff failed to ensure: 1. All items were labeled and dated in the kitchen refrigerator. 2. The counter tops and shelves were clean. 3. The floors throughout the kitchen were clean. 4. The heated plate dispenser (a device used to heat and store plates prior to use) was clean. These deficient practices are likely to affect all 115 residents listed on the resident census provided by the Administrator on 02/17/25 and are likely to lead to foodborne illnesses in residents. The findings are: A. On 02/17/25 at 10:15 am, observation of the kitchen revealed the following: 1. Two liquid pitchers, one was full of red liquid, and one was full of white liquid, on the bottom shelf in the refrigerator was not labeled to indicate the type of contents and not dated with the date the liquid was made. 2. The counter tops and shelves throughout the kitchen had food particles, spilled liquid, and dust on them. 3. The floors throughout the kitchen had food particles, spilled liquid, trash, and dust on them. 4. The heated plate dispenser had food particles, spilled liquid, and dust on the top and in the inserts that hold the plates. B. On 02/17/25 at 11:17 am, during an interview with the Culinary Manager (CM), he stated that all food and drink items should be labeled and dated. The CM confirmed that counter tops, shelves, floors, and heated plate dispenser did not meet his expectations. He stated his expectations are for the kitchen and everything in it to be clean.

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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 observation, interview, and record review, the facility failed to provide respiratory care (health care discipline specializing in the promotion of optimum cardiopulmonary (promotion of health and wellness in the respiratory system (lungs)) function, that was consistent with professional standards of practice for 2 (R #46 and R #62) of 5 (R #4, R #8, R #46, R #62 and R #72) resident sampled for respiratory care when staff failed to change R #46's and R #62's nasal cannula (medical device to provide supplemental oxygen therapy to through the nose) within seven days of the previous change. This deficient practice could likely cause the nasal cannula to become obstructed, non-functional, and unsanitary and not provide the resident with the oxygen needed. The findings are: R #46 A. On 02/17/25 at 11:35 AM, during an observation of R #46's room, revealed R #46 had an oxygen concentrator (a device that removes nitrogen from the air to provide oxygen-enriched air) by his bed and nasal cannulas (a thin, flexible tube that delivers oxygen through the nose) hanging on his bed. The nasal cannula was not dated with a date indicating the date the cannula had been changed. B. Record review of R #46's Physicians Orders dated 02/20/22, revealed oxygen at 2 Liters administered via nasal cannula every shift. C. On 02/17/25 at 11:16 AM, during an interview, the Assistant Director of Nursing-Facility Wide (ADON-FW) stated the oxygen cannulas are changed once a week, usually on Sundays. The ADON said there should be a piece of tape on the tubing with a date to document when the tubing was changed. The ADON stated that the tape on the tubing is how they document when the cannulas were changed. The ADON confirmed that R #72's cannula does not have a date indicating when the cannula was changed, and she could not confirm if R #72's cannula had been changed. D. On 02/17/25 at 1:55 PM, during an interview, CNA #6 confirmed R #46's nasal cannula does not have a date indicating when the nasal cannula was changed. CNA #6 said that the nasal cannulas are usually changed on Sundays, and she could not confirm if R #46's nasal cannula had been changed. R #62 E. On 02/17/25 at 11:05 AM, during an observation of R #62's room, revealed R #62 had an oxygen concentrator and nasal cannula next to her bed. The nasal cannula was not dated with a date indicating the date the cannula had been changed. F. Record review of R #62's Physicians Order dated 01/17/25 revealed oxygen at 2 Liters administered via nasal cannula every shift.

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NAME OF PROVIDER OR SUPPLIER Las Estancias by Pure Health		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 Las Estancias Dr SW Albuquerque, NM 87121	

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to offer the influenza (for Flu virus, a highly contagious viral respiratory infection that affects the nose, throat, and sometimes the lungs) vaccine for 1 (R #8) of 5 (R #3, R #4, R #8, R #15, and R #46) residents reviewed for immunizations. If residents are not given the opportunity to consent or decline the vaccine as appropriate against the flu, then they have a higher likelihood of contracting the illness and spreading it to other residents in the facility. The findings are: A. Record review of R #8's Electronic Health Record (EHR) revealed staff failed to offer the influenza vaccination to R #8. B. On 02/21/25 at 11:15 am, during an interview with the DON, she confirmed R #8's EHR does not contain any evidence that the facility offered the influenza vaccination to R #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to offer COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) vaccinations to 1 (R #8) of 5 (R #3, R #4, R #8, R #15, and R #46) residents reviewed for COVID-19 vaccinations. This deficient practice could likely result in residents getting COVID-19. The findings are: A. Record review of R #8's Electronic Health Record (EHR) revealed the record did not contain any COVID-19 vaccine forms which indicated staff offered or administered the COVID-19 vaccine to the resident. B. On 02/21/25 at 11:15 am, during an interview with the DON, she confirmed R #8's EHR does not contain any evidence that the facility offered the COVID-19 vaccination to R #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER: Las Estancias by Pure Health		STREET ADDRESS, CITY, STATE, ZIP CODE: 3620 Las Estancias Dr SW Albuquerque, NM 87121	

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of 12 hours per year for 3 (CNA #1, CNA #2, and CNA #3) of 5 (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5) CNAs reviewed for required in-service training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are: CNA #1 A. Record review of CNA #1's personnel file revealed CNA #1's Caregiver Criminal History Screening (background check for employment at the facility) was cleared on 07/31/22. B. Record review of CNA #1's in-service training Transcript Report, dated 02/21/25, revealed CNA #1 did not complete any training past 08/07/23. C. On 02/21/25 at 1:23 pm, during an interview with the Administrator (ADM), she confirmed the facility does not have any evidence of CNA #1 completing any training past 08/07/23. The ADM confirmed CNA #1 continued to work shifts providing care for residents in the facility even though the facility has no proof of ongoing training. The ADM stated she expects all CNAs to complete at least 12 hours of training per year. CNA #2 D. Record review of CNA #2's personnel file revealed CNA #2's Caregiver Criminal History Screening was cleared on 12/13/22. E. Record review of CNA #2's in-service training Transcript Report, dated 02/21/25, revealed CNA #2 did not complete any training past 08/16/23. F. On 02/21/25 at 1:23 pm, during an interview with the ADM, she confirmed the facility does not have any evidence of CNA #2 completing any training past 08/16/23. The ADM confirmed CNA #2 continued to work shifts providing care for residents in the facility even though the facility has no proof of ongoing training. CNA #3 G. Record review of CNA #3's personnel file revealed CNA #3's Caregiver Criminal History Screening was cleared on 04/09/21. H. Record review of CNA #3's in-service training Transcript Report, dated 02/21/25, revealed CNA #3 did not complete any training past 08/07/23. I. On 02/21/25 at 1:23 pm, during an interview with the ADM, she confirmed the facility does not have any evidence of CNA #3 completing any training past 08/07/23. The ADM confirmed that CNA #3 continued to work shifts providing care for residents in the facility even though the facility has no proof of ongoing training.