STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 N Renaissance Blvd 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure 1 (R #1) of 1 (R #1) resident reviewed received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being by not ensuring that staff received the appropriate training to mitigate resident aggressive behaviors. This deficient practice likely resulted in R #1 attacking an Certified Nurse Assistant (CNA), resulting in R #1 falling. The findings are:A. Record review of R #1's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses (including but not limited to): 1. Fournier gangrene (an infection), 2. Unsteadiness on feet, 3. Cognitive communication deficit (affects the ability to communicate effectively due to impairments in cognitive processes), 4. Depression (feeling of sadness and loss of interest), 5. Cerebral infarction (stroke or CVA [cerebrovascular accident], blood flow to a part of the brain is obstructed). B. Record review of R #1's care plan dated 11/24/25 revealed the following: 1. Problem start date (11/23/25) Witnessed fall caused while resident was being aggressive trying to kick and hit the aide resulting in this fall. Approach: SSD (Social Services director) will start looking a place to discharge the resident too due to physically combative with by kicking hitting and punching staff. Problem start date 10/02/25 (name of R #1 requires splint to right hand pinky finger due to fracture.2. Problem: start date 09/16/25(Name of R #1) has been physically abusive towards other residents. Goal: Resident will not harm self or others secondary to physically abusive behavior.Approach: Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Obtain a Psych consult/psychosocial therapy. Provide 1:1 oversight with resident as needed. No other interventions identified. 3. Problem: start date 06/26/25 (Name of R #1) has a history of anxiety and depression.Approach: Convey an attitude of acceptance toward the resident. Encourage resident to verbalize feelings and fears. Clarify misconceptions. Establishing a trusting relationship with the resident. Report emergence of signs of isolation. No other interventions identified. C. Record review of current active (12/29/25) physicians orders revealed the following:Buspirone HCl oral tablet 10 MG (milligrams) one tablet daily for depression.Sertraline HCl oral tablet 50 MG give 1 tablet daily for depression.Trazodone HCl 50 MG give 0.5 table daily for insomnia.D. On 12/23/25 at 11:36 am, during an interview with R #1, he recalled being upset on the night of 11/22/25, when the wound dressing on his legs got wet after the shower, immediately R #1 asked Licensed Practical Nurse (LPN) #1 to complete the dressing change to both legs. After just wrapping the left leg, LPN #1 left and brought staff with her and R #1 felt threatened with the presence of staff not assigned to him that night. R #1 stated CNA #1 came in and told (CNA #2) that he would provide the care needed to R #1. R #1 asked CNA #1 to leave. CNA #1 did not leave the room when asked to leave by R #1. R #1 felt that CNA #1 was provoking him when he did not leave and walked around the bed to start to provide care. R #1 felt as if CNA #1 was intimidating him due to the aggressive behavior he showed to LPN #1. R #1 stood on his feet and (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attack CNA #1. R #1 felt he was acting in self-defense when CNA #1 did not leave his room and when he proceeded to walk around his bed. R #1 stated he got into a wrestling match with CNA #1 and remembered falling to the floor and the only way to defend himself was by kicking CNA #1. R #1 also stated that more staff came in once he was on the floor and CNA #1 left and the rest of the staff helped him back to bed. R #1 was unable to recall if CNA #1 had caused the injury R #1 further stated it was late at night and he was so angry he went to bed and the next morning when he woke up, he felt pain on his pinky finger. E. On 12/26/25 at 10:40 am, during an interview with CNA #1, he stated the night of 11/22/25, CNA #2 (who had been asked by LPN #1) came to ask him to help her with R #1's care (getting his pants up as requested by LPN #1). CNA #1 stated R #1 is known for his aggressive behavior. CNA #1 entered R #1's room and asked CNA #2 to stay at the door while he provided care. CNA #1 asked R #1 what was going and R #1 started yelling at him to leave. CNA #1 replied we are just here trying to help you. CNA #1 stated he went around the bed to have a better view of his ostomy bag (a collection pouch to catch urine or stool), and immediately R #1 jumped him and cornered him. R #1 started swinging at him and R #1 immediately fell to the floor and continued kicking CNA #1. CNA #1 stated that as soon as he was able to move away from R #1 (CNA #2, LPN #1 and another staff [does not recall the name of the staff]) started coming in and CNA #1 proceeded to leave the room. CNA #1 further stated that R #1 had a prior incident with another resident and he was the CNA that intervened in the incident, after that incident R #1 had a negative attitude toward him.G. On 12/26/25 at 12:14 pm, during an interview with LPN #1, she recalled the night of 11/22/25, R #1 had a nasty attitude. LPN #1 went in the room after R #1 had a late shower to provide dressing change to his legs. LPN #1 stated she made the decision to remove herself from the situation (as she felt threatened by R #1's increase aggressive behavior) after providing wound care (does not remember the exact treatment provided) and asked CNA #2 to help R #1 pull his pants up. CNA #2 grabbed CNA #1 and entered the room. LPN #1 stated that a few minutes later, she heard CNA #2 yelling the resident is fighting [name of CNA.] LPN #1 quickly ran back to the room with the other night staff (do not recall which staff came in with her) and saw CNA #1 standing by bed A (bed A is empty, and R #1 is assigned to bed). LPN #1 further stated she did not see the actual altercation and saw R #1 on the floor. LPN #1 went straight to R #1 and asked him to try to calm down so they can assist him back to bed.H. On 12/26/25 at 2:06 pm, during an interview with the Administrator, she stated they took CNA #1 off the schedule immediately pending investigation. The administrator also stated that she was unable to get a hold of CNA #1 and subsequently terminated him when she substantiated her investigation. On 11/24/25 she concluded that CNA #1 had all the opportunity to remove himself from the situation and that did not happen. Immediately after the incident the administrator conducted abuse re-training and de-escalation training for the staff. On 11/28/25 they conducted safe interviews with all the residents, especially the residents CNA #1 was assigned and did not find any similar situations. Administrator further stated that all staff when hired is giving an abuse/neglect training but not de-escalation or any other training for staff related to managing difficult or aggressive behaviors. De-escalation training was conducted with staff after 11/23/25. I. On 12/29/25 at 8:03 am, during an interview with CNA #2, she stated LPN #1 asked her to help R #1 pull his pants up. CNA #2 stated she is not assigned to R #1 and is aware of R #1's behavior, so she asked CNA #1 for help. CNA #2 stated that as soon as R #1 saw CNA #1, he started yelling profanity to CNA #1. CNA # 2 stated that the next thing she saw was R #1 on his feet attacking CNA #1. CNA #2 quickly asked for help and LPN #1 and another nurse showed up. CNA #2 also stated that R #1 is nice to everyone except CNA #1 because of a prior incident (incident when CNA #1 intervened between R #1 and another resident). ?