STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325033	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Rancho Center	4210 Sabana Grande SE Rio Rancho, NM 87124

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45428 Based on record review and interview, the facility failed to ensure that residents representative were notified following a room change and bed bug discovery for 2 (R # 95 and 42) of 3 (R #95, 42, and 105) residents reviewed for room changes or bed bug issues. If the facility is not notifying the residents responsible party of room changes or other issues then the resident representative will not have an opportunity to advocate on behalf of the resident. The findings are: A. Record review of R #42 and R #95's facesheets revealed both residents had a responsible party listed. B. Record review of progress notes revealed no attempt to contact the resident representatives for R #95 or R #42. C. On 10/14/21 at 9:53 am during an interview with Director of Nursing (DON) she stated that the responsible party for each resident should be informed of room changes and other changes. When asked if the residents representatives were notified of the room changes and the bed bugs DON stated there was no record of residents representatives for R #95 or R #42 being contacted by the facility. D. On 10/14/21 at 11:25 am during an interview with resident representative for R #95, she stated there was no form of contact made by the facility to inform her of R #95's room change or having bed bugs present in the R #95's room.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide follow up report within 5 working days from the date of the incidents to the State Survey Agency, for 2 (R's #281 and 282) of 2 (R's #281 and 282) residents reviewed for incidents. If the facility fails to report incidents to the State Agency, then the State Agency will be unable to assure residents a safe and hazard free environment. The findings are: Findings for R #281: A. Record review of R #281's progress notes dated [DATE] revealed, THIS NURSE RESPONDED TO RESIDENT IN THE DINING ROOM NOTED BY CNA [Certified Nursing Assistant] TO HAVE HER HEAD DOWN AND FACE 'BLUE'. THIS NURSE ASSESSED RESIDENT AND NOTED RESIDENT NON RESPONSIVE, EYES OPEN WITH PUPILS DILATED, RESIDENT IMMEDIATELY TRANSPORTED PER GERI CHAIR [a large padded chair designed to help seniors with limited mobility] TO HER ROOM AND HER NOTED CODE STATUS IS FULL CODE, RESIDENT PLACED ON FLOOR WHEN CPR [Cardiopulmonary Resuscitation- an emergency procedure that involves chest compressions] INITIATED AND 911 CONTACTED AND RESPONDED. RESIDENT TRANSFERRED OUT VIA STRETCHER WITH APPARENT RHYTHM (had a heartbeat)TO [Name of local hospital]. B. Record review of R #281's face sheet revealed R #281 was discharged on [DATE] due to Other: _Resident deceased . C. On [DATE] at 3:29 pm during an interview with the Administrator (ADM), she stated, The deposition of what occurred [R #281 incident on [DATE]] stated they [staff] thought it was a heart attack and it [R #281 incident on [DATE]] was not reported [to State Agency (SA)]. ADM confirmed the incident that occurred to R #281 on [DATE] was never reported to the SA and it should have been. Findings for R #282: D. Record review of R #282's progress notes dated [DATE] revealed, Note: Patient was found to be choking in bed while being fed by CNA's and NA's [Nursing Aides]. Patient was not responsive to verbal or physical stimuli, (does not respond to noise or touch) Vitals signs showed an oxygen saturation [O2 sat] of 31% [percent]. (blood oxygen content and oxygen delivery). At the time a bolus [a small round mass of substance, especially of chewed food at the moment of swallowing] of food was seen to be in patients mouth. Bolus taken out with finger and patient placed on a non-breather mask [a device used to assist in the delivery of oxygen] at 15 L [liters]. Patients O2 sat climbed to 65% before EMS [Emergency Medical Services] arrived. Patient breathing, still not responsive to verbal or physical stimuli. E. Record review of R #282's face sheet revealed R #282 was discharged from the facility on [DATE]. F. On [DATE] at 3:31 pm during an interview with the ADM, she stated, I didn't know the nature of the incident as I wasn't here, but we looked everywhere for it [Incident report for R #282 incident on [DATE]]. I can't find a record of it. It [R #282 incident on [DATE]] should have been reported.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview, the facility failed to meet professional standards for 5 (R #'s 46, 69, 94, 113 and 114) of 5 (R #'s 46, 69, 94, 113 and 114) residents by: 1. Not doing weekly skin checks for R #46 and R #69 in accordance with the physician's order. 2. Not labeling, dating, and changing O2 (oxygen) tubing in accordance with standards of practice and care plan for R #94 and R #114. 3. Not providing anticoagulation medication (blood thinner) monitoring in an acceptable time frame for R #113. 4. Providing oxygen (O2) to R #114 without physician orders. If the facility is not performing weekly skin checks, providing non ordered treatments to residents, not performing anticoagulation medication monitoring, and not changing and labeling O2 tubing as ordered, then residents are likely to not receive the therapeutic benefits and care they need. The findings are: Weekly Skin Check Findings for R #46: A. Record review of face sheet revealed R #46 admitted [DATE] with multiple diagnosis including Chronic Diastolic Congestive Heart Failure (heart disease that affects pumping action of the heart muscles) and Cellulitis (bacterial infection of the skin). B. Record review of R #46 Physician Orders revealed order dated 06/04/21 for Weekly Skin Check by Licensed Nurse on night shift every Friday. C. Record review of R #46 Observation History (list of skin checks) revealed R #46 did not receive a weekly skin check as follows: 1. 06/04/21 2. 07/02/21 3. 07/16/21 4. 07/23/21 5. 07/30/21 6. 09/10/21 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. During interview on 09/29/21 at 1:26 PM Director of Nursing (DON) confirmed she is familiar with R #46 and confirmed R #46 is currently being followed by the wound nurse for actual skin breakdown. DON confirmed R #46 had several missing skin checks. DON confirmed the expectation is for residents to have skin checks weekly by licensed nurse as ordered. Weekly Skin Check Findings for R #69: E. Record review of R #69 revealed admitted [DATE] with multiple diagnosis including Personal History of Traumatic Brain Injury (A head injury causing damage to the brain) and Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or the inability to move on one side of the body) following Cerebral Infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area). F. Record review of R #69 Physician orders revealed order dated 04/08/21 for Weekly skin check by licensed nurse on day shift every Friday. G. Record review of R #69 Observation History (list of skin checks) revealed R #69 did not receive a weekly skin checks from 03/26/21 to 06/04/21. H. On 09/28/21 at 2:57 pm during interview DON confirmed R #69 did not receive weekly skin checks between 03/06/21 and 06/04/21. DON confirmed the expectation is for residents to have skin checks weekly by licensed nurse as ordered. DON confirmed if weekly skin checks are not completed then changes in skin condition might be missed and wounds and sores would go unnoticed and untreated. 41988 Findings for R #94: I. Record review of R #94's physician orders dated 09/16/21 revealed, Oxygen at 2L (liters)/min (minute) Nasal Cannula (a device used to deliver supplemental oxygen or increased airflow). J. On 09/21/21 at 10:03 am during an interview and observation with R #94, R #94 was observed wearing O2. R #94's O2 tubing is not dated or initialed. K. On 09/21/21 at 10:09 am during an interview with Certified Nursing Assistant (CNA) #4, she stated, It [R #94's O2 tubing] looks new, but it [R #94's O2 tubing] should be labeled and dated and it's not. L. On 09/21/21 at 4:49 pm during an interview with the Director of Nursing (DON), she stated, It [R #94's O2 tubing] should have been labeled when it was changed. M. Record review of R #94's physician orders dated 09/16/21 revealed,Oxygen tubing change weekly, Label each component with date and initials, every day shift, every Sun (Sunday) Label each component with date and initial. Findings for R #113: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. Record review of R #113's physician orders dated 05/20/21 revealed, Xarelto Tablet (blood thinner to treat and prevent blood clots) 10 MG (milligrams), Give 1 tablet by mouth one time a day for dvt (deep vein thrombosis- a blood clot in the in a deep vein, usually in the legs) prevention. O. Record review of R #113's physician orders dated 09/26/21 revealed, Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V [nausea and vomiting], diarrhea, muscle joint pain, lethargy (lack of energy and enthusiasm periods of weakness), bruising, sudden changes in mental status and, SOB [shortness of breath], nose bleeds-document 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'other/see nurses notes' and progress note findings. P. On 10/04/21 at 9:17 am during an interview with the DON, she stated, He [R #113] went a while without the order [for anticoagulant medication monitoring]. It [anticoagulant medication monitoring order] should have been in their physician orders. DON confirmed the order to monitor anticoagulant medication use for R #113 should have been input with the initial medication order and not several months later. Findings for R #114: Q. Record review of R #114's physician orders revealed no physician order for O2 use. R. On 09/20/21 at 12:41 pm during an interview and observation, R #114 is observed wearing O2 tubing that was not dated or initialed. R #114 stated, I just started wearing it [O2] recently in here [facility]. S. On 09/20/21 at 12:46 pm during an interview with CNA #6, she stated, He [R #114] wears it [O2] off and on. It [R #114's O2 tubing] should be labeled. CNA #6 confirmed R #114 was wearing O2. T. On 09/21/21 at 4:49 pm during an interview with the DON, she stated, It [R #114 O2 use] should be ordered. DON confirmed R #114 should have physician orders for O2 use.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview the facility failed to ensure that a discharge was properly documented in the resident's medical record and provide a discharge summary for 1 (R #97) of 1 (R #97) resident reviewed for discharge. This deficient practice is likely to result in residents not having what they need for a safe discharge. The findings are: A. Record review of R #97's Admission Record revealed admitted [DATE] and discharge date of [DATE]. B. Record review of Discharge Plan Documentation for R #97 dated 09/18/21 sections A. Social Services, B. Unit Clerk - Administrative, and C. Recreation were incomplete. All sections required signature and dates were blank. C. Record review of Physician order dated 09/16/21 for R #97 stated, OK to discharge home on 09/18/21 with all medications. Home health to evaluate and treat for Physical Therapy/Occupational Therapy/Speech Therapy/Registered Nurse/Home Health Aide, Durable Medical Equipment: hospital bed. D. On 09/30/21 at 10:20 am during interview with Social Service Assistant (SSA) confirmed R #97 Discharge Plan was not completed and confirmed it should be completed and signed by staff completing the assigned sections. SSA confirmed because the document was incomplete there is not a way to show the resident or family was provided with the residents status or ensure the resident received what was needed for a safe discharge.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview, the facility failed to provide ADL (activities of daily living) assistance for baths/showers for 6 (R #'s 28, 46, 71, 113, 117, and 279) of 6 (R #'s 28, 46, 71, 113, 117, and 279) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: Findings for Resident #28 A. On 09/20/21 at 2:33 pm during interview R #28 stated, I don't always get my scheduled showers. I didn't get my shower on Saturday (09/18/21) so I wont get one till Wednesday. If they (staff) miss my shower they (staff) won't give me one in between my scheduled days. B. On 09/22/21 at 5:21 pm during interview Licensed Practical Nurse (LPN) #6 stated she was informed on report (passing of duties from outgoing nurse to on coming nurse) that there was only 3 Certified Nurse Assistants(CNA's) to cover the south halls during the morning shift on (09/22/21). LPN #6 stated she is not sure how everything could get done on the morning shift with only 3 CNA's and staff was not able to provide showers during the morning shift. LPN #6 reviewed R #28 bath/shower documentation and confirmed R #28 had only one shower documented for the month of September which was today (09/22/21). C. Record review of R #28 medical record revealed R #28 was offered and/or received a shower on 09/22/21. No other bath/showers were documented for R #28 for the month of September 2021. D. On 09/27/21 at 12:13 pm during interview with Director of Nursing (DON) she stated the expectation is for residents to be offered a shower twice a week and for bathing to be documented in the resident's electronic medical record in the assigned CNA documentation section and on the weekly bath/shower sheets. DON confirmed R #28 did not have any documented showers in his electronic medical record for the month of September 2021 to show R #28 was offered or received bath/showers. Findings for Resident #46 E. On 09/20/21 at 4:15 pm during interview with R #46 she stated, I would like to take more showers. We get one maybe once a week. If I ask for one they will not give me one if it's not scheduled. Sometimes I don't get one when it is scheduled because they say there is not enough staff to give me a shower. F. Record review of R #46 medical record revealed R #46 was offered and/or received showers on 09/06/21, 09/19/21, and 09/27/21. G. On 09/27/21 at 12:13 pm during interview with DON she confirmed R #46 should be offered a shower a minimum of twice weekly. DON confirmed R #46 was not offered or received bath/showers twice weekly as expected. 45428 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings for Resident #71 H. On 09/20/21 at 12:26 during an interview with R #71, she stated. Nursing staff has no time for me and I do not always get my showers as wanted or needed. I would like to have showers done regularly and they (staff) tell me that they do not have time or they are short staffed. I. On 09/23/21 at 1:26 pm during an interview with Certified Nursing Assistant(CNA) #10 she stated, it is difficult to assist R #71 due to lack of staff. J. Record review of shower sheet for the month of September 2021 revealed R #71 had only been offered showers on 09/16/21 and 09/22/21. 41988 Findings for R #113: K. Record review of R #113's care plan dated 05/24/21 revealed, Focus- Resident/Patient is at risk for decreased ability to perform ADL(s) related to: Limited mobility. Interventions- Provide resident/patient with extensive assist for bathing. L. Record review of R #113's Documentation Survey Report dated September 2021 revealed R #113 had not been offered a bath/shower for the entire month. M. Record review of R #113's bath/shower logs located at the nurses station revealed no bath/shower logs present for R #113. N. On 09/20/21 at 3:58 pm during an interview with R #113, he stated, I usually get bed baths and I didn't get one for at least two weeks. I shouldn't have to baby sit these people that are only giving me one [bed bath] a week. I was angry and filled out a grievance for it. O. On 09/23/21 at 9:27 am during an interview with CNA #10, when asked where residents showers and baths are documented if they are provided a bath or a shower or refused a bath or a shower. She stated, It's [resident baths/showers] documented in the shower book and ADL's [in the electronic health record (EHR)]. P. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, We have scheduled shower days, but sometimes we don't get to them. They [resident baths/showers] should be documented in the shower logs and [Name of EHR]. If it's [R #113's baths/showers] not there [in EHR or shower log], then it didn't happen. He [R #113] never refuses and he [R #113] likes his baths. Q. On 09/23/21 at 1:04 pm during an interview with Licensed Practical Nurse (LPN) #4, she stated, There's nothing in here [shower logs for R #113]. I don't have anything in there [shower logs] for him [R #113]. It [R #113 offered baths/showers] has not been charted in here [EHR] either. LPN #4 confirmed there is no documentation that shows R #113 was offered a bath/shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, They [residents] should be offered [a bath or shower] twice a week. They [staff] should be documenting it [bath/shower] in [Name of EHR] and on the shower sheets. I have no additional documentation that proves it [baths/showers] was getting done. Findings for R #117: S. Record review of R #117's care plan dated 05/29/21 revealed, Focus-Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: generalized weakness. Interventions- Provide resident/patient with total assist of 1 for bathing. T. Record review of R #117's Documentation Survey Report dated September 2021 revealed R #117 refused one bath/shower on 09/01/21, but R #113 had not been offered any other bath/shower for the rest of the month. U. On 09/21/21 at 9:35 am during an interview with R #117, she stated, I feel grungy and I smell myself. I need at least one shower a week and I'm not getting that. V. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, She [R #117] never refuses and she likes her showers. W. On 09/23/21 at 9:46 am during an interview with CNA #6, she confirmed residents will miss showers due to there not being enough staff available. X. On 09/23/21 at 1:05 pm during an interview with LPN #4, she stated, I see nothing charted for her [R #117] either. Y. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, She's [R #117] going to have to get bed baths only because she's very compromised. (very frail, sick) DON confirmed R #117 was not offered baths/showers as expected. Findings for R #279: Z. Record review of R #279's face sheet revealed R #279 was admitted into the facility on [DATE]. AA. Record review of R #279's care plan dated 09/21/21 revealed, Focus-Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to: nausea/vomiting. pain, recent acute illness with recent surgery. Interventions- Provide resident/patient with extensive assist of 1 for bed mobility. transfers, toileting care, colostomy care, (care on how to change, empty or clean the the pouch system used to collect human waste) mobility, personal hygiene, and bathing. BB. Record review of R #279's Documentation Survey Report dated September 2021 revealed R #279 had not been offered any bath/shower for the month. CC. On 09/21/21 at 12:07 pm during an interview with R #279, she stated, I haven't taken take a shower. I don't like laying here 4-5 days without being cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DD. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, If she's [R #279] not in the book and I can't find it [documentation of baths/showers being offered], then I can't say it [baths/shower] happened.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 On [DATE], R #281 was found unresponsive in the dining room. Resident was transferred from the dining room to the resident's room before CPR was initiated. R #281 later died . On [DATE], R #283 was found unresponsive in his room following the lunch meal service. Before CPR was initiated, Nurse went to the Nurse's station to look up resident's code status and call 911. CPR was not immediately initiated until full code status was confirmed in the electronic medical record. R #283 was not able to be revived and pronounced deceased . On [DATE] and [DATE] Nursing staff (licensed nurses and certified aides) were interviewed and found to be unaware of resident's advance directives (a resident's code status which describes their wish to either accept or reject emergency intervention such as Cardiopulmonary Resuscitation). Nursing staff stated they must have access to resident's electronic health record (EHR) (a medical resident found on an electronic device such as a computer) to access and identify resident's code status. Nursing Staff stated that EHR's can be found at the computers located at the two facility nurses stations (an area in which staff maintain resident records and computers) or at the front desk. Nursing staff stated that in the event of a resident found non-responsive (unconscious and unable to respond) they would go to the nearest nurses station, review the resident's EHR then return to the residents location with that information to be provided to others on scene or begin treatment according to resident wishes. Nursing staff further stated that if they were to find a non-responsive resident they would begin CPR until the resident's code status was confirmed. Nursing Staff further stated that if they started CPR for a resident found unresponsive they would stop CPR if the resident's codes status was found to be DNR (Do Not Resuscitate: a person's request to not receive emergency intervention). This is process is reported as being the facility policy. This resulted in an Immediate Jeopardy (IJ) at a scope and severity of K (a pattern of jeopardy to resident health and safety) being identified on [DATE] at 1:47 pm. A Plan of Removal was received and rejected on [DATE] at 11:15 am. A Plan of Removal was received and rejected on [DATE] at 12:18 pm. A Plan of Removal was received and accepted on [DATE] at 12:56 pm. Based on this Plan of Removal, the interventions included: 1. An audit of all residents was completed on [DATE] to verify that resident code status orders are congruent (equivalent and the same) with the MOST (Medical Orders for Scope of Treatment) form (a standardized form signed by each resident indicating their wishes to be followed in the event of a medical emergency such as a heart attack). This was completed by the Center Nurse Executive (CNE). Corrective action was taken as necessary to ensure accuracy of resident code status. 2. A printed list of each resident's code status will be carried by each licensed nurse and Certified Medication Aide (CMA) beginning [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Licensed nursing staff will be educated on Code Status Orders and Cardiac and/or Respiratory Arrest policies and procedures, as well as maintaining an updated printed document which identifies each resident's code status. The document will be carried on their person at all times while on duty beginning [DATE] or before their next scheduled shift. 4. All facility staff will be educated on procedures related to finding a resident unresponsive. 5. A random audit will be completed 5 times per week for 4 weeks then monthly for 2 months to verify that licensed nurses and CMA's have the printed list of current code status on their person. Based on the Plan of Removal, the Scope and Severity was reduced from the Level of K to H (actual harm). Based on record review and interview, the facility failed to ensure that personnel would be able to provide basic life support to residents requiring emergency care without delay for those residents that have been identified as wanting intervention, and not initiate basic life support for residents' whose wish is to not have intervention. This deficient practice is likely to result in residents who desire emergency intervention to have treatment delayed which is likely to result in death; or residents who do not desire emergency intervention to have unwanted emergency interventions started, resulting in resident receiving severe injuries and unwanted results (Broken bones, punctured lungs, undesired revival). The findings are: Findings for R #281: A. Record review of the complaint allegation received by the State Agency identified While unattended during meal she [R #281] choked and was found dead. Report states she was not a DNR but no one attempted any life saving measures. B. Record review of R #281's progress notes dated [DATE] revealed, This nurse responded to resident in the dining room noted by CNA (Certified nursing assistant) to have her head down and face 'blue'. This nurse assessed resident and noted resident non responsive, eyes open with pupils dilated, resident immediately transported per geri chair [a large padded chair designed to help seniors with limited mobility] to her room and her noted code status is full code, resident placed on floor when CPR [cardiopulmonary resuscitation- an emergency procedure that involves chest compressions] initiated and 911 contacted and responded. Resident transferred out via stretcher with apparent rhythm (had a heartbeat) to [name of local hospital]. C. On [DATE] at 11:11 am during interview with Licensed Practical Nurse (LPN) #1 regarding R #281, she stated A CNA came to the desk and she informed me there was a patient she wanted me to see that wasn't eating, her [R #281] face was blue and her pupils were small. She was taken to her room. LPN #1 described that R #281 was leaning over the table when found and was wheeled in the geri-chair back to her room while being unresponsive. LPN #1 reported that she requested another nurse to call code blue. LPN #1 confirmed she responded to the unresponsive resident in the dining hall and did not begin CPR until the resident was brought to her room due to privacy issues. LPN #1 stated that it was easier to move the resident to her room, than to clear all the residents from the dining room to start CPR. LPN #1 confirmed that she did not immediately know R #281's code status until she was informed by another nurse. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings for R #283 D. Record review of R #283's progress notes dated [DATE] revealed, The CNA stated that around 12:00 p. m. the residents food tray was placed in his room, and then between 12:15 p.m. and 12:20 p.m. the resident was observed unresponsive when the residents meal tray was being picked up from his room. The attending nurse was immediately notified, and CPR was initiated as the resident has a Full Code Status. In addition to CPR the AED [Automated External Defibrillator- portable electronic device used to help those experiencing sudden cardiac arrest] defibrillator was also implemented, Crash Cart was brought to the room, suctioning of mouth was started to suction out food particles observed in the mouth and throat. Paramedics (911) were called and dispatched and they arrived at around 12:40 p.m. RN (Registered Nurse) contacted Emergency Contact #1 at 12:45 p.m. to inform him of the residents change In condition. Paramedic arrived and they implemented CPR and other measures but were unsuccessful in their attempt to stabilize the resident, and he passed on. I was called into the room by paramedic prior to them leaving to show me a medium size piece of meat that was laying next to the resident. At 12:50 p.m. RN informed the on-call clinical supervisor again to inform him of the residents passing away, he stated he will contact [Name of local medical investigator]. RN contacted [Name of Emergency Contact #1] to inform him of the residents passed away . RN did the pronunciation and time of death was 1:16 p.m. E. Record review of R #283's face sheet with a print date of [DATE] revealed R #283 was a Full Code. F. On [DATE] at 10:56 am during an interview, the Director of Nursing (DON) stated The CNA found him [R #283] when she went to collect a tray. She [CNA] called the two nurses. Everybody [residents] had metal utensils except for the fork. The piece [of food in R #283's mouth] we found wasn't that tough and we were able to pull it out and I gave that to [Name of local medical investigator]. G. On [DATE] at 11:10 am during an interview with LPN #5, she stated, I didn't go into the room [R #283's room]. I prepared paperwork for him [R #283] and called 911. As soon as we knew there was something going on [R #283 unresponsive], I went to the desk [nursing station] and looked at his [R #283] code status and called 911. It just seems like everyone [staff] went automatically [to R #283's room] when we knew [R #283's code status]. As far as I know, CPR didn't begin [on R #283] until everyone was notified [of R #283's code status]. LPN #5 confirmed she had to go the nurses station to find out R #283's code status and relay that information to the staff in R #283's room before CPR could begin. Findings related to code status: H. Record review of resident census dated [DATE] revealed a census of 107 residents I. Record review of Advance Directive Order Listing Report provided on [DATE] by facility Infection Preventionist revealed that 60 residents requested they be considered as full code (a person's request to receive full emergency intervention should they become unresponsive) should they require emergency intervention. The remaining 47 residents requested they be considered as Do Not Resuscitate and directing that no emergency interventions be provided should they become unresponsive. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	J. On [DATE] at 2:42 pm during interview with the DON she stated that all licensed nursing staff (Registered Nurses and Licensed Practical Nurses) have completed a hands on CPR class in compliance with the American Heart Association in which all were trained in the standard procedure to respond to a resident who is found to be unresponsive. K. On [DATE] at 3:21 pm during interview with LPN #4, she stated that if a resident were found unresponsive she would assess the resident, place the resident in a position and begin doing CPR, she would call somebody to go and look at the medical record [to confirm their code status] before I go and do something, but of course you want to save someone's life. I would start CPR. I have 30 residents, some I've had for more of a long time but for the newer ones I'd have to look (their code status in the medical records) . My people in the front (unit front hallway) I'd automatically assume they are a full code except for the hospice . It's a judgment call. LPN #4 confirmed she would ask staff to clear a room and check a residents code status before beginning CPR. LPN #4 also confirmed she would consider moving an unresponsive resident if possible. L. On [DATE] at 4:11 pm during an interview with LPN #3, she stated, I would approach them [resident] and ask if it would be ok to help them. I would call for help. I would move them [choking resident] to a safer place and I would make sure it was Ok to administer CPR and I would ask someone to check [resident code status]. If I knew they were a full code, I'd start CPR. M. On [DATE] at 9:23 am during interview with Certified Medication Aide (CMA) #3, when asked what she would do if she found a resident unresponsive, she stated I would report it to the nurse. I would have to check the resident's code status. Yeah, of course it would take time. I would try to get them to their room or somewhere with no other residents around [before starting CPR]. N. On [DATE] at 9:30 am during interview with CMA #4, she confirmed that she is CPR certified but that she does not know residents code statuses. CMA #4 confirmed that if she found a resident unresponsive, she would try to arouse them and if not she would get the nurse. Regarding code statuses, CMA #4 stated It's on the computer. It would cause a little delay cause I would have to check the computer or call out for some else to check [code status] if we [staff] weren't by a computer. O. On [DATE] at 9:57 am during interview with Physical Therapist (PT) #1, he confirmed that he is CPR certified however he only knows the code statuses of the residents he works with. If he found a resident unresponsive, he stated that he would call the nurse. P. On [DATE] at 10:01 pm during interview with RN #2 he stated, As an RN, I would try to find out what's going on .I would call the doctor and do CPR and call 911 regardless of their code status. I would get them on a hard surface as quickly as possible. Usually we don't know off the bat (what their code status is) but it's on the screen [at the Nurse's Station computer] and usually we keep a list of code statuses, but I don't see it here right now. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Q. On [DATE] at 11:11 am during interview with LPN #1 she stated We should know everyone's code status, but unfortunately, we would have to send someone to check the code status [of an unresponsive resident]. This happened with a patient a long time ago [referring to R #281] .I'd do everything I could to take care of it (resident's needs) and send someone for help to check their code status. I don't know their (residents) code status. I would start (CPR) immediately, I would start CPR even if I didn't know their code status. LPN #1 stated that it would be reasonable to take up to one minute to locate a resident's code status in the medical record however anything longer than a minute would be considered wasting time to start CPR. R. On [DATE] at 3:08 pm during interview with Regional Nurse Leader (RNL), she stated that Staff should start CPR until the resident's code status can be confirmed. If the resident is DNR, we stop CPR. That is the facility policy. By the time we get the crash cart we know the code status. It's [a resident's code status] on the MAR and TAR [Treatment Administration Record], and iPads for aides on [name of electronic health record]. The nurses station is centrally located. We should keep a printed copy of code statuses. 41988

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview the facility failed to provide quality of care for injuries and medication use by not: 1. Assessing for injuries for R #'s 41 and 46. 2. Identifying injuries for R #'s 41 and 46 3. Providing timely notification to a physician for R #'s 41 and 46. 4. Providing important medications for R #282. The deficient practice is likely to result in residents pain not being addressed, discomfort, and a diminished quality of life. The findings are: Findings For R #41: A. Record review of R #41 Progress note dated 09/22/21 stated that a skin check was completed and no new injuries were noted. B. On 09/221/21 at 2:00 pm during observation R #41 was observed to have bruising to her upper left arm on the under side and three bruises to the top of her left wrist. R #41 expressed some discomfort. C. On 09/22/21 at 2:05 pm during interview Licensed Practical Nurse (LPN) #1 stated, I did do the skin assessment on her (R #41) this morning and do not recall her having bruising when I checked her. LPN #1 then went to check R #41 and confirmed R #41 had bruising to her left upper arm on the under side and three bruises on the top of her wrist. LPN #1 stated the bruising under her (R #41) arm appears old. LPN #1 stated bruising should be documented in the residents medical record, the physician should be notified and the residents responsible party should be notified. LPN #1 confirmed R #41 at that time did not have bruises documented and the physician and responsible party were not notified. Findings For R #46: D. Record review for R #46 revealed a bath and skin report dated 09/19/21 with documented redness rash, peeling blisters, open areas, and bruises. Bath and skin report dated 09/19/21 section to be signed by the nurse was blank. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 09/22/21 at 4:00 pm during interview LPN #6 confirmed she is familiar with R #46 and is aware of an area on her (R #46) sacrum (low back) that had open area that is currently being monitored and has scabs on her (R #46) left shin that LPN #6 stated come and go. LPN #6 confirmed she was not aware of R #46 having any bruising or redness rash. LPN #6 stated she did not work on 09/19/21 and was not made aware of anything new being reported. LPN #6 stated the expectation is for the Certified Nurse Assistant (CNA) to report skin conditions to the nurse. The nurse would then determine if it is new or something the nurse is already aware of and monitoring or providing treatment. If it is, determine the condition is new then the nurse should assess the resident and notify the provider. LPN #6 confirmed there is no documentation by a nurse in R #46 medical record to show that R #46 was assessed by a nurse and there is no documentation that the provider was notified. F. On 09/29/21 at 1:26 pm during interview with the Director of Nursing (DON), she confirmed she is familiar with R #46 and is aware of R #46 having an open area to her sacrum and areas to her left shin that have been described as peeling or blisters. DON confirmed she is not aware of R #46 having redness rash or bruising. DON stated the expectation is for the CNA to notify the nurse of any skin condition found while providing care. DON stated the form requires a nurse to sign off on the form to acknowledge he/she was informed by the CNA. DON verified the bath and skin report dated 09/19/21 was not signed by a nurse. DON stated skin conditions should be assessed by a nurse and should have a documented action taken which should include notifying the DON and physician for directions for further action. DON confirmed she was not aware of R #46 bruising and redness and rash and she confirmed R #46 was not assessed by a nurse on 09/19/21 to address bruising and redness rash and physician was not informed. 41988 Findings For R #282: G. Record review of R #282's face sheet revealed R #282 was admitted into the facility on [DATE] and discharged on [DATE]. H. Record review of R #282's progress notes (as written in the electronic health record) dated 05/11/21 revealed, Note: RN [Registered Nurse] spoke with resident's sister (POA- Power Of Attorney) to notify her that the resident is needing refills on Anti-viral medications Prezcobix 800-150 mg [milligram] tablet and Tivicay (medication used to treat Human Immunodeficiency Virus) 50 mg tablet. She stated she will contact the pharmacy to try to obtain medications. RN provided phone numbers of pharmacy used to contact. I. Record review of R #282's Medication Administration Record (MAR) for May 2021 revealed R #282 was administered Prezcobix 800-150 mg and Tivicay 50 mg, on 05/11/21 and 05/12/21 only. J. On 09/28/21 at 9:41 am during an interview with R #282's POA, she confirmed R #282 went several days without his HIV (Human Immunodeficiency Virus- interferes with the body's ability to fight infections) medications once R #282 returned to the facility. K. On 09/30/21 at 2:48 pm during an interview with the Director of Nursing (DON), she stated, It is our [facility] responsibility to make sure he [R #282] and all facility residents have their current physicians ordered medications. DON further confirmed R #282 went several days without his HIV medication and should not have.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review, observation, and interview, the facility failed to ensure that residents receive the necessary treatment and services to promote healing of pressure ulcers (skin damage which results from unrelieved pressure on the body) for 2 (R #42 and #113) of 2 (R #42 and #113) residents reviewed, by not identifying and beginning treatment of pressure ulcers immediately, and performing weekly skin assessments for a resident susceptible to pressure ulcers. This deficient practice is likely to result in residents' pressure ulcers not healing and/or getting worse. The findings are: Resident #42 A. Record review of R #42's face sheet revealed she was admitted to the facility on [DATE] with multiple diagnoses including Dementia (a disease of the brain that results in a decline in memory), Cerebral Infarction (a open blood vessel located in the brain causing internal bleeding and pressure), Malignant Neoplasm (a cancer) of the Female Breast. B. Record review of R #42's daily care notes revealed the following: 09/17/21 A skin check was performed. No skin injury/wounds were noted. 09/22/21 Has a small open skin area to the left side of her buttock, tender to touch. 09/26/21 Wound dressing changed to left buttock/sacral area, wound has increased in size since noted by this nurse on 09/23/21, Tx (treatment) per order. C. Record review of R #42's physician orders dated 09/27/21 revealed an order to begin wound care to a sacral (buttock) area. D. Record review of R #42's Treatment Administration Record dated 09/28/21 revealed that no wound care had been documented on or before 09/28/21. E. On 09/29/21 at 1:30 pm during interview with Registered Nurse (RN) #2, he stated that he was the nurse assigned to monitor wound care for the facility. He stated that he was aware of R #42's sacral wound. He stated that he had observed the wound and stated that it was small in size, was skin deep with minimal fluid accumulation. RN #2 reviewed the daily care notes and confirmed that the notes were correct and that R #42's wound had been identified on 09/22/21 and that treatment should have commenced (start) immediately. He also stated the providing physician should have been notified of the new wound immediately. He stated that initial treatment of any wound can commence without a physician's order and can include placing a cream over the wound or placing a bandage over the wound. He confirmed there was no indication this had occurred prior to 09/26/21. 41988 Findings for R #113: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #113's care plan dated 05/24/21 revealed, Focus- Resident is at risk for skin breakdown: d/t (due to) hx (history) of vascular ulcers to right foot and left heel. Interventions Observe skin condition daily with ADL (Activities of Daily Living) care and report abnormalities, and Weekly skin check by license nurse. G. Record review of R #113's skin assessment page with a print date of 09/28/21 revealed R #113 received skin assessments on 08/14/21, 08/21/21, and 09/18/21. H. On 09/28/21 at 10:30 am during an interview with the Nurse Practitioner (NP), she stated, Their [facility] staffing is terrible and the person that does wound care is often pulled to the [nursing] floor. They [nursing] should be doing a weekly skin assessment. They [nursing] should be doing a weekly skin assessment at the bare minimum. I. On 09/28/21 at 2:48 pm during an interview with the Director of Nursing (DON), she stated, He [R #113] should have regular skin checks. DON confirmed R #113 did receive weekly skin assessments between 08/21/21 and 09/18/21, and should have been been receiving weekly skin assessments.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44363 Based on interview and record review, the facility failed to ensure resident specific physician orders and ongoing communication and collaboration (different persons/groups working together) with the dialysis (clinical purification of blood as substitute for normal kidney functioning) facility regarding dialysis care and services for 2 (R #10 and 51) of 2 (R #10 and 51) residents reviewed for dialysis. If the facility is unaware of the status, condition, or complications that arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: Findings for R #10 A. Record review of R #10 Nursing Documentation Note dated 05/29/21 revealed that daily documentation of R #10's care was to be completed daily and include all nursing services and assessments provided to R #10 including Dialysis. None of the nursing documentation notes included any reference to Dialysis. B. Record review of R #10 Physician Orders revealed no order for R #10 to receive Dialysis. C. Record review of R #10 Medical Record revealed no documentation addressing the status or condition before and after Dialysis treatments. D. On 09/28/21 at 2:50 pm during interview with Director of Nursing (DON) she confirmed R #10 was being transported by the facility to a dialysis clinic three times per week, on Tuesdays, Thursdays, and Saturdays. DON confirmed there was not a physician order in R #10 medical record for Dialysis and confirmed R #10 should have had an order for Dialysis. DON confirmed that nursing staff should document the resident's condition, vital signs and any other relevant information prior to being transported to Dialysis. Nurses should then document the resident's condition and any other relevant information upon return from dialysis. DON was unable to provide any such documentation for R#10. 41988 Findings for R #51: E. Record review of R #51's physician orders dated 06/29/20 revealed, Dialysis center phone number is: _____Dialysis days: _____ Time for Pick up: _____ Transport to: _____Nephrologists' (a physician who specializes in the treatment of kidney disease) name: _____Phone Number: _____. R #51's dialysis order was not completed or resident specific. F. Record review of R #51's facility Dialysis Communication Record revealed forms for the following dates, 07/02/21, 07/19/21, 07/23/21, 07/30/21, 08/13/21, 08/27/21, and 08/30/21. Each form provided is incomplete and sections required by the facility to complete pre and post dialysis is blank. (continued on next page)

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	325033	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Rancho Center	4210 Sabana Grande SE Rio Rancho, NM 87124

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 09/28/21 at 3:01 pm during an interview with the Director of Nursing (DON), she confirmed R #51's physician orders for dialysis were not complete or specific for R #51 dialysis use and should have been. DON also stated, I would expect us [facility] to fill it [Dialysis Communication Forms] out. DON also confirmed R #51's Dialysis Communication Forms were not filled out by the facility and should have been.