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	09/23/2022

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide reasonable accommodations of resident needs and preferences for 1 (R #5) of 1 (R #5) residents reviewed by not: 1. Ensuring R #5 was properly groomed 2. Ensuring R #5 was dressed in his own clothing and not in a hospital gown. This deficient practice is likely to result in residents feeling embarrassed and that their preferences are not important to the facility. The findings are: A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE]. B. Record review of R #5's Minimum Data Set (MDS) Section C- Cognitive Patterns dated 07/05/22 revealed R #5 has a Brief Interview for Mental Status (BIMS- used to identify a resident's current cognition and help determine if any interventions need to occur) is 00 (0-7 suggests severe impairment, 8-12 suggests moderate impairment, and 13-15 suggests the patient is cognitively intact). C. On 09/20/22 at 10:48 am during an observation, R #5 was observed wearing a hospital gown that exposed his back and underwear in the activity room while seated in a wheelchair, his hair was disheveled. R #5 gestured to this writer to observe his gown by pulling at his hospital gown. When asked if he would like to wear his own clothing he shook his head indicating Yes and continued tugging at his gown. D. On 09/20/22 at 10:50 am during an interview with Licensed Practical Nurse (LPN) #4, she stated, No [R #5 should not be wearing a hospital gown], he's [R #5] normally dressed [in regular clothes]. I'm not sure if he's [R #5] out of clothes. E. On 09/20/22 at 11:08 am during an interview with Certified Nursing Assistant (CNA) #2, she stated, He [R #5] should be in [regular] clothes. F. On 09/22/22 at 4:29 pm during an interview with the Director of Nursing (DON), he stated, He [R #5] would be at least offered to be helped with dressing. Even if the BIMS is that [00]. DON confirmed R #5 should have been assisted by staff with wearing regular clothes and not a hospital gown. 34439

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 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** 41988 Based on record review and interview, the facility failed to provide ADL (Activities of Daily Living) assistance for baths/showers for 3 (R #'s 1, 2, and 4) of 4 (R #'s 1, 2, 3, and 4) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: Findings for R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and discharged on [DATE]. B. Record review of R #1's care plan dated 06/13/22 revealed, Focus: While in the facility, [Name of R #1] states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to her preferences. [Name of R #1] is admitted at the facility for P/T [physical therapy], O/T [occupational therapy] following hospitalization for UTI [urinary tract infection], WOUND. She is alert and oriented and is not interested in group activity offered. Intervention: It is important for me to choose between a tub bath, shower, bed bath or sponge bath- prefer shower. C. Record review of R #1's documentation survey report (facility task report) dated 06/10-06/27/22 revealed R #1 was not offered or given a bath/shower during that time. D. Record review of R #1's weekly bath and skin report dated 06/10-06/27/22 revealed no shower logs were provided for R #1. E. On 09/19/22 at 3:34 pm during an interview with R #1's son, he stated, My mom [R #1] takes a bath every day whether she had her leg amputated or not. I would have to ask the nurse to bathe her [R #1] because she was never given a bath or shower. I don't know if they ever did [provide R #1 with a bath or shower]. F. On 09/22/22 at 1:57 pm during an interview with the Director of Nursing (DON), he stated, I'd expect [residents to be offered a bath/shower] twice a week, unless the resident only wants one [bath/shower]. DON confirmed R #1 did not have baths/showers offered and should have. Findings for R #2: G. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE] and discharged on [DATE]. H. Record review of R #2's care plan dated 06/24/22 revealed, Focus: Resident/Patient requires assistance/is dependent for ADL care in dressing, bed mobility, transfer, locomotion, toileting related to: hip surgery. Intervention: Provide resident/patient with extensive assist of 1 for bathing. I. Record review of R #2's documentation survey report dated 05/23-05/31/22 revealed R #2 was not offered or given a bath/shower during that time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #2's weekly bath and skin report dated 05/23-05/31/22 revealed no shower logs were provided for R #2. K. Record review of R #2's documentation survey report dated 06/01-06/23/22 revealed R #2 was not offered or given a bath/shower during that time. L. Record review of R #2's weekly bath and skin report dated 06/01-06/23/22 revealed no shower logs were provided for R #2. M. On 09/22/22 at 1:58 pm during an interview with the DON, he confirmed R #2 did not have baths/showers offered and should have. Findings for R #4: N. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE]. O. Record review of R #4's care plan dated 07/19/22 revealed, Focus: [Name of R #4] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting r/t [related to] Parkinson's disease (disorder of the central nervous system that affects movement) and generalized weakness. Intervention: Provide resident/patient with extensive assist for bathing. P. Record review of R #4's documentation survey report dated 08/01-08/31/22 revealed R #4 was only offered 1 bath/shower for the entire month. Q. Record review of R #4's weekly bath and skin report dated 08/01-08/31/22 revealed R #4 was given 2 baths/showers for the month. R. Record review of R #4's documentation survey report dated 09/01-09/23/22 revealed R #4 was not offered or given any baths/showers during that time. S. Record review of R #4's weekly bath and skin report dated 09/01-09/23/22 revealed R #4 was given/offered 3 baths/showers during that time. T. On 09/23/22 at 1:28 pm during an interview with R #4, he stated he does not get baths/showers enough and wants at least 2 baths/showers a week. R #4 stated he feels awful when not given a bath/shower after an extended period of time. U. On 09/23/22 at 1:33 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated R #4 does not refuse baths/showers. V. On 09/23/22 at 1:46 pm during an interview with the DON, he confirmed R #4 was not offered enough baths/showers and should have been.

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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 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** 34439 Based on record review, observation, and interview the facility failed to ensure that 2 (R #3 and #4) of 2 (R #3 and 4) resident reviewed for pressure ulcers received care and treatment that met the resident's needs by not being aware of the skin condition of the residents. If the facility fails to provide the highest level of care to it's residents, then residents physical, mental and psychosocial well being may decline. The findings are: Findings R #3 A. Record review of R #3's face sheet revealed R #3 was admitted on [DATE]. B. Record review of Physicians orders dated 10/24/22 revealed, Wound care: right knee skin tear. Cleanse with NS (normal saline), pat dry place Skin Flap over wound bed, apply Xerofoam gauze wrap (type of cloth used on wound care) loosely and secure with tape on dressing only. Every day shift for skin tear. C. Record review of nursing note dated 10/25/22 revealed, Apply to bilat (bilateral-both sides) great toes topically one time a day for wound care. D. Record review of wound report dated 10/01/22-10/26/22 did not reveal a wound for R #3 great toe or the right knee skin tear or the treatments for either wounds. E. On 10/26/22 at 3:30 pm during an interview with the Clinical Director, she stated. It (order) was entered wrong in the order it is not a pressure wound and all wounds should be on the wound report. F. On 10/26/22 at 3:35 pm during an interview with the wound care nurse he stated, I am not going to say I didn't know about it, I just don't remember this exact skin tear. I am not sure where we missed skin tear for her (R #3), provider did measure and there is an order for care and as far as the wound on the toes I don't believe there are any wounds on the toes. Findings for R #4 G. On 10/27/22 at 11:00 during random observation of R #4's wound dressing it was observed to have a date of 10/24/22. H. On 10/27/22 at 11:05 during an interview with the Minimum Data Set (MDS) Coordinator she confirmed that dressing change for R #4 had not been changed since 10/24/22 and it should have been changed daily. I. Record review of physicians order dated 10/24/22 reveled , Wound care: Bilateral buttocks. Cleanse with NS, pat dry, apply Z-guard (ointment used protect skin) to affected area. every shift for MASD (Moisture Associated Skin Damage). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of Treatment Administration Record dated 10/01/22 to 10/27/22 revealed dressing was last changed on 10/24/22 day shift.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, interview, and record review, the facility failed to: 1. Ensure that a resident with Pressure Ulcers (an injury to the skin and underlying tissue, caused by prolonged pressure on the skin) received the necessary treatment and services, consistent with professional standards of practice 2. Ensure wound care orders were initiated for R #1's pressure wound and leg amputation upon admission to the facility. 3. Ensure there was adequate communication with an offsite provider to begin wound care for R #2 resulting in delayed wound care for R #2. 4. Ensure there was documentation consistently in accordance with wound care orders for R #1's pressure wound, and R #3's new skin issue. This deficient practice resulted in R #1's right knee amputation becoming infected and requiring emergent medical attention, R #2's wound care orders and treatment to be delayed without proper communication, and R #3 to develop a new skin injury that was not reported or documented to facility staff and providers. If the facility is not ensuring that wound care orders are initiated, followed, provided and communicated, then residents wounds will worsen and are likely to acquire new skin issues and wounds to worsen. The findings are: Findings for R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: 1. METABOLIC ENCEPHALOPATHY [problem in the brain caused by an imbalance in the blood] 2. SEPSIS [harmful microorganisms in the blood], UNSPECIFIED ORGANISM 3. URINARY TRACT INFECTION, SITE NOT SPECIFIED 4. ACUTE RESPIRATORY FAILURE WITH HYPOXIA [deficiency in the amount of oxygen reaching tissues] 5. CYSTITIS [inflammation of the urinary bladder], UNSPECIFIED WITHOUT HEMATURIA [blood in 6. ACQUIRED ABSENCE OF LIMB, UNSPECIFIED 7. PHANTOM LIMB SYNDROME WITH PAIN 8. UNSPECIFIED PROTEIN-CALORIE MALNUTRITION 9. MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. CHRONIC PAIN SYNDROME 11. HEART FAILURE, UNSPECIFIED 12. PERIPHERAL VASCULAR DISEASE, UNSPECIFIED 13. HYPOTENSION [low blood pressure], UNSPECIFIED 14. PRESSURE ULCER OF SACRAL REGION, STAGE 3 15. PRESSURE ULCER OF OTHER SITE, UNSTAGEABLE 16. MUSCLE WEAKNESS (GENERALIZED) 17. DYSPHAGIA [difficulty or discomfort in swallowing], OROPHARYNGEAL PHASE 18. OTHER ABNORMALITIES OF GAIT AND MOBILITY 19. PAIN, UNSPECIFIED 20. WEAKNESS 21. OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD R #1 was discharged on [DATE] to the hospital. B. Record review of R #1's History and Physical dated [DATE] revealed, Chief Complaint/ Nature of Presenting Problem: She (R #1) is being admitted for wound care therapy following complications of an above-the-knee amputation. Plan: Wound Care. C. Record review of R #1's physician orders dated [DATE] revealed, Wound care: Cleanse with normal saline. Apply medi honey and bordered gauze. Pressure injury knee right, distal (distance further from the center of the body)-unstageable Acquired [DATE] Present on arrival one time a day for wound care to knee. D. Record review of R #1's care plan dated [DATE] revealed, Focus: [Name of R #1] is at risk for skin breakdown related to_____ and or has actual skin breakdown Type:_____ Location_____ Pressure injury knee right, distal -unstageable Acquired [DATE] Present on arrival. Interventions: Provide wound treatment as ordered, Weekly skin check by license nurse, Weekly wound assessment to include measurements and description of wound status. E. Record review of R #1's Treatment Administration Record (TAR) dated [DATE] to [DATE] revealed wound care was not documented as completed to R #1's right knee pressure injury on [DATE], [DATE], and [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F. Record review of the facility Weekly Wound Report dated [DATE] to [DATE] revealed R #1 was on the wound report one time on [DATE]. The [DATE] report stated, SS Drainage (drainage containing blood). No other weekly wound reports were provided by facility that included R #1's wounds. G. Record review of R #1's progress notes dated [DATE] to [DATE] revealed no wound care progress noted for R #1's right knee amputation wound care. H. Record review of R #1's progress notes dated [DATE] at 9:17 am revealed, Resident was complaining of pain at the amputation site, right AKA [above-knee-amputation]. Wound is moist, with redness on the surrounding area. Doctor assessed the area and referred the resident to the ER [emergency room]. Taken to [Name of local hospital] by [Name of local ambulance service]. I. Record review of R #1's Medical Doctor (MD) progress note dated [DATE] revealed, Chief Complaint/Nature of Presenting Problem: Worsening pain and exposed bone at stump site. History of Present Illness: They [facility staff] report that she [R #1] has increase exposed bone, stump breakdown, and a foul order. She [R #1] is having worsening pain. [.] She does have some necrotic [death of cells or tissue through disease or injury] drainage. Plan: She [R #1] will be transferred to the Emergency Department, she [R #1] will need surgical attention, [.] and her [R #1] prognosis is very poor. J. Record review of R #1's Emergency Department Provider Notes dated [DATE] at 1:48 pm revealed, Patient [R #1] discussed with [Name of ED physician]. He [ED physician] has reviewed the patient's [R #1] chart and he states the patient will likely need a revision of her amputation [a revision procedure may be necessary to address tissue breakdown, chronic pain, scarring, or other health issues] based on findings on CT [Computed Tomography] imaging. Discussed Vancomycin and Zosin (antibiotics) for broad antibiotic coverage. Number of Diagnoses or Management Options: Above knee amputation of right lower extremity, Myositis [muscle inflammation] of right thigh, unspecified myositis type Osteomyelitis [inflammation of bone or bone marrow] of right femur, unspecified type Wound dehiscence [splitting or bursting open of a pod or wound]. Diagnosis management comments: The patient is an [AGE] year-old female who presents to the ER [emergency room] for evaluation of right leg pain found to have wound dehiscence with osteomyelitis, myositis, cellulitis [inflammation of subcutaneous connective tissue] at the wound site. It is unclear when this wound dehiscence occurred but patient was evaluated in this emergency department on [DATE]. At that time [[DATE]], she [R #1] was found to have an intact wound with no evidence of dehiscence. She was treated for UTI [Urinary Tract Infection]. [.] It is possible that her [R #1's] findings on CT imaging are chronic in nature. However, given that she has exposed distal femur a wound site, she [R #1] will need operative management. I discussed the patient with orthopedics, [Name of ED physician] He is agreeable to consult and likely revise the amputation. Patient [R #1] will need infectious disease and possibly surgery as well. At this time she has no evidence of systemic infection. Patient was given vancomycin [antibiotic] and Zosyn [antibiotic] in consultation with orthopedics. Given relatively normal labs, normal vital signs, low suspicion for necrotizing fasciitis [a serious bacterial infection that destroys tissue under the skin], patient was not given clindamycin [antibiotic] in the emergency department. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	K. On [DATE] at 3:30 pm during an interview with R #1's son, he stated, My mother already had her leg amputated [prior to arriving in facility]. The wound specialist at [Name of facility] never saw my moms wound and she [R #1] said she went 10 days without anybody looking at it [wound on her right knee]. She [R #1] was sent to the hospital again and it [R #1's right knee amputation] was so infected that they [hospital] had to re-amputate it again. What they [facility] did to her [R #1] in that home (nursing facility), they took the little life she had left. I don't think she's [R #1] going to make it to be honest with you. I feel like they [facility] took her [R #1's] life away and I can't even bring her [R #1] home. L. On [DATE] at 2:47 pm during an interview with Registered Nurse (RN) #1, he stated, I usually get wound care, measure wounds, and document them weekly, on Saturday or Sunday. I usually do it [wound care] weekly. I'm not sure why that [R #1 not being on the weekly wound report until [DATE]] happened. The orders are there for them [nursing staff] to provide wound care and they [nursing staff] should document in the notes what they see, what they did, and if there's a photo they should document it. There is a policy that we are supposed to document [wound care]. M. On [DATE] at 2:23 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated, Pressure ulcer injury care was on there [for R #1]. It does look like she [R #1] had wound care orders on the [DATE]. There is some nursing documents on ,d+[DATE] [2022], ,d+[DATE], and ,d+[DATE]. I don't know why [there aren't notes documented for R #1's wound care after [DATE] until [DATE]]. N. On [DATE] at 2:38 pm during an interview with RN #2, he stated, I think the orders [for R #1's right knee wound care] was every other day. I remember her [R #1] being sent out [to the ED] because she had signs of infection and when they [nursing staff] were doing wound care, they [nursing staff] noticed the wound was infected and the doctor decided to send her [R #1] out [to the ED]. It [R #1's right knee wound care] was every other day. Only the nurses who were assigned [to R #1] were the ones taking care of the wound. We [facility] didn't have a wound specialist. The time she [R #1] was sent out [to the ED], I was told the wound was infected. O. On [DATE] at 3:09 pm during an interview with Medical Doctor (MD) #1, he stated, I can't tell you how often they [facility nursing staff] would have communicated with me [about R #1's wounds]. I saw her [R #1] before they sent her out [to the ED] because she [R #1] had worse pain and what was stated there [in R #1's [DATE] MD Progress Note]. There was 100% [percent] wound dehiscence [partial or total separation of previously approximated wound edges, due to a failure of proper wound healing] and the [right knee] stump had fallen apart. P. On [DATE] at 3:30 pm during an interview with LPN #2, she stated, The admitting nurse will enter all the orders in and they [admitting nurse] are required to do a head to toe assessment and that's all documented. If there are wound care orders in the paperwork, that gets entered into the chart. When wound care is done, depending on if pain meds are administered, they [nursing staff] are to document how they [residents] tolerated it [wound care], what was done, and basically the interaction with the resident when they [nursing staff] were doing it [wound care]. So we have a kind of sort of wound care nurse [RN #1] and when he's [RN #1] not being utilized on the floor. When that [RN #1 conducting wound care] doesn't happen, we have the floor nurses do their own wounds. LPN #2 confirmed R #1's wound care should have been documented in R #1's progress notes and was not. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Q. On [DATE] at 4:07 pm during an interview with the Director of Nursing (DON), he stated. The expectations are they [nursing staff] should be documenting when they are doing wound care, letting skin lead know [any wound changes], and any complications [with wound care]. We tried to have some sort of documentation [for resident wound care]. We [facility] document that it [wound care] was done and any exceptions within it. There should have been something documented [for R #1's wound care between [DATE] to [DATE]]. There should have been a documentation of that [R #1's right knee wound] change. Our typical [wound] measurement period is every 7 days, that would be the expectation. R. On [DATE] at 9:44 am during an interview with the Nurse Practioner (NP) #1, she stated, They [facility nursing staff] tell me [Name of RN #1] is doing the wound care. When you talk to [Name of RN #1], he says he only fills in [for wound care]. There's no wound care person onsite. I was getting wound reports at one time, but I haven't seen one [wound report] in a bit. If I'm only here two days a week, it's hard to keep up with that [resident wound care]. There's supposed to be an area in [Name of Electronic Health Record (EHR) with wounds, I don't have access to it and I don't know why. That [R #1's wound worsening] would be something the nursing staff would notify us and they [R #1] would need to be sent back to the surgeon. I don't get [wound] measurements or what the wound looks like. They [facility] don't have a wound care specialist. I can take a look at it and give suggestions, but it is not my position to be a wound care provider here. He's [RN #1] not wound care certified and he's [RN #1] not a wound care nurse. If there is a wound infection, they [resident] need to be seen by the surgeon immediately. Findings for R #2: S. Record review of R #2's face sheet revealed R #2 was admitted on [DATE] with the following diagnoses: 1. UNSPECIFIED OPEN WOUND OF SCROTUM AND TESTES, SUBSEQUENT ENCOUNTER 2. INFLAMMATORY DISORDERS OF SCROTUM 3. ANAL ABSCESS [swollen area within body tissue] 4. DISRUPTION OF EXTERNAL OPERATION (SURGICAL) WOUND, NOT ELSEWHERE CLASSIFIED, SEQUELA (an aftereffect of a disease, condition, or injury) 5. BENIGN PROSTATIC HYPERPLASIA [prostate gland enlargement] WITH LOWER URINARY TRACT SYMPTOMS 6.DISRUPTION OF EXTERNAL OPERATION (SURGICAL) WOUND, NOT ELSEWHERE CLASSIFIED, SUBSEQUENT ENCOUNTER 7. COVID-19 [deadly respiratory virus] 8. URINARY TRACT INFECTION, SITE NOT SPECIFIED (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. ANEMIA [deficiency of red blood cells], UNSPECIFIED 10. HYPERLIPIDEMIA [high concentration of fats or lipids in the blood], UNSPECIFIED 11. [NAME] SYNDROME [condition which the liver doesn't properly process bilirubin] 12. UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE 13. UNSPECIFIED HEARING LOSS, BILATERAL 14. UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE 15. UNSPECIFIED ASTHMA, UNCOMPLICATED 16. MUSCLE WEAKNESS (GENERALIZED) 17. OTHER ABNORMALITIES OF GAIT AND MOBILITY 18. REPEATED FALLS R #2 expired on [DATE] and was discharged to a local funeral home. T. Record review of R #2's offsite provider physician orders dated [DATE] revealed, Wound Care Consultation. U. Record review of R #2's progress notes dated [DATE] at 11:39 pm revealed, Patient was admitted /readmitted for the following reason(s): Wound Care perineal abscess (a collection of pus in the tissue around the anus and rectum), UTI [Urinary Tract Infection] Additional details about this note: multiple wounds. V. Record review of R #2's progress notes dated [DATE] at 1:08 am revealed, assessment complete, rsd [resident] does have multiple severe wounds that will require wound care and monitoring. No wound care orders were sent with resident on admission. will refer to wound care nurse for appropriate orders. W. Record review of R #2's progress notes dated [DATE] at 11:15 pm revealed, Remains alert and HOH [hard of hearing]. Able to communicate. No specific c/o [complaint of] pain or discomfort. Packing remains in place to perineal wound (the area of skin and muscle between the vaginal opening and the anus). RN [Registered Nurse] from [offsite provider] called and stated that she would be in ,d+[DATE] [pm on] , d+[DATE] to assess the wound(s) and would do a telehealth call with the DR [doctor] to determine tx [treatment] and clarify orders in question. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	X. Record review of R #2's progress notes dated [DATE] at 12:18 pm revealed, RESIDENT AWAKE AND ALERT IN HIS BED THIS SHIFT. DENIES PAIN/DISCOMFORT. THIS NURSE CONTACTED SOCIAL WORKER WITH [Name of offsite provider] THIS AM TO SEEK DIRECTION ON HAVING [Name of offsite provider] PROVIDER ADVISED OF NEEDED ASSESSMENT OF RESIDENT'S AS NEW ADMISSION AND NUMEROUS WOUNDS. SOCIAL WORKER WITH [Name of offsite provider] REFERS THIS NURSE CONTACT CLINIC OFFICE. OFFICE NUMBER CALLED AND NO ANSWER. WILL CONTINUE TO ATTEMPT REACHING [Name of offsite provider] FOR ORDER CLARIFICATIONS, INCLUDING WOUND CARES. CURRENTLY WOUNDS ARE TO BE MONITORED Q [every] SHIFT AND NEW CHANGES REPORTED. Y. Record review of R #2's progress notes dated [DATE] at 1:28 pm revealed, NURSE CASE MANAGER FROM [Name of offsite provider] HERE THIS SHIFT AND RESIDENT'S ORDERS WERE CLARIFIED AND CONFIRMED. WOUND TREATMENTS OBTAINED AFTER ALL WOUNDS WERE ASSESSED BY CASE MANAGER RN. RESIDENT HAS RESTED WITHOUT C/O THIS SHIFT. WOUND CARE WAS PROVIDED TO ALL WOUNDS. RESIDENT CONTINUES TO HAVE PENDING ORTHO (correction of deformities of bone and muscle) AND UROLOGY (branch of medicine concerned with the function and disorder of the urinary system) CONSULT. Z. Record review of R #2's physician orders dated [DATE] at 2:45 pm revealed, TREATMENT ORDER FOR WOUND TO THE LEFT UPPER BUTTOCK: CLEANSE AREA WITH NORMAL SALINE, PAT DRY, APPLY MEDIHONEY PAD, COVER DAILY WITH BORDER DRESSING AND PRN [as needed] SOILAGE/DISLODGEMENT. R #2's wound care began in facility on [DATE]. AA. Record review of R #2's physician orders dated [DATE] at 3:30 pm revealed, CLEANSE ANTERIOR AND POSTERIOR SURGICAL TESTICLE INCISION WITH NORMAL SALINE, PAT DRY, PACK WITH IODOFORM TAPE, MAY COVER WITH PLAIN GAUZE TO SECURE, DAILY AND PRN SOILAGE. BB. Record review of R #2's physician orders dated [DATE] at 10:00 am revealed, TREATMENT ORDER FOR UNSTAGEABLE LEFT HEEL WOUND: CLEANSE AREA WITH NORMAL SALINE, PAT DRY, APPLY SANTYL [ointment] AND COVER WITH OPTIFOAM, WRAP WITH KERLIX [wrap/bandage roll] DAILY. CC. Record review of R #2's physician orders dated [DATE] at 10:00 am revealed, TREATMENT ORDER FOR OPEN WOUND ON THE LEFT OUTER KNEE, GENTLY CLEANSE SKIN SURROUNDING EXPOSED METAL PROSTHETIC, PAT DRY. DO NOT GET DEVICE WET. APPLY ABDOMINAL PAD TO COVER SITE, WRAP WITH KERLIX. DD. Record review of R #2's progress notes dated [DATE] revealed, THERAPY HAS BEEN NOTIFIED THAT RESIDENT IS NOW PALLIATIVE CARE AND COMFORT MEASURES. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	EE. On [DATE] at 11:49 am during an interview with LPN #3, she stated, He [R #2] was a [Name of offsite provider] resident and was on the north unit. When he [R #2] came [to the facility], he had a stage 2 [pressure ulcer] on his bottom, unstageable on his left or right heel, and he had a surgical procedure done on the knee and metal prosthesis (an artificial device that replaces a missing body part) exposed. I'm not sure, but I know [Name of offsite provider] will come and make orders to continue the care for him [R #2]. It took a little while [to get wound care orders for R #2 from the offsite provider] and a [Name of offsite provider] manager came out and she had the doctor on the zoom and the doctor saw his [R #2's] wounds. I need orders from the [Name of offsite provider] physicians for wounds or medicine. I need orders from [Name of offsite provider] and sometimes it [physician orders from offsite provider] takes time. He [R #2] came with orders for medications and things, but for the wounds he had, there was no clear cut orders for that and his prosthesis. For me, they [offsite providers] needed to see him [R #2] and provide orders. LPN #3 confirmed R #2's wound care was delayed when he was admitted to the facility because of a lack of communication between the facility and offsite provider. FF. On [DATE] at 2:53 pm during an interview with RN #1, he stated, He [R #2] had exposed prosthesis [implant] underneath. There was some talk about that [R #2's delayed wound care treatment due to communication issues with offsite provider]. I had difficulty getting an order for the knee [from the offsite provider] because he [R #2] had a prosthesis so we left it alone on the prosthesis side. Generally, we [facility] talk to our doctor, and with [Name of offsite provider], there is a little communications issue with [Name of offsite provider] and us [facility]. Our [facility] doctors don't want to handle [Name of offsite provider] patients for some reason and when [Name of offsite provider] is involved, they [Name of offsite provider] call the shots on [Name of offsite provider] orders. [Facility] Staff made attempts to get orders [for R #2's wound care] because we were concerned about not doing nothing. RN #1 confirmed R #2's wound care was delayed when he was admitted to the facility because of a lack of communication between the facility and offsite provider. GG. On [DATE] at 3:42 pm during an interview with LPN #2, she stated, The communication [between the facility and offsite provider] is definitely delayed. We [facility] just do what they [Name of offsite provider] tell us. I talk to the [facility] staff, but I do let [Name of offsite provider] know I need further instructions [for wound care]. Our in house physician won't tell us [staff] what to do with that [residents who use offsite provider]. LPN #2 confirmed R #2's wound care was delayed when he was admitted to the facility because of a lack of communication between the facility and offsite provider. HH. On [DATE] at 4:25 pm during an interview with the DON, he stated, If [physician] orders are sent with the patient, we try to get those orders in. We do have difficulties with getting things from [Name of offsite provider]. I have my unit managers communicate with them [Name of offsite provider]. DON confirmed communication issues between the facility and the offsite provider. All orders are entered into the medical chart by the facility staff and any communication that is done is entered into the nurses progress notes by facility staff. Findings for R #3: II. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: 1. HYPOTHYROIDISM [abnormally low activity of the thyroid gland] UNSPECIFIED (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. SPONDYLOSIS [painful condition of the spine resulting from degeneration of the intervertebral disks], UNSPECIFIED 3. PRIMARY OSTEOARTHRITIS [type of arthritis that occurs when flexible tissue at the ends of bones wears down], UNSPECIFIED SITE 4. ADULT FAILURE TO THRIVE 5. OTHER ABNORMALITIES OF GAIT AND MOBILITY 6. MUSCLE WEAKNESS (GENERALIZED) 7. HYPERLIPIDEMIA, UNSPECIFIED 8. PERSONAL HISTORY OF COVID-19 9. ANOREXIA [lack or loss of appetite for food] 10. PRESSURE ULCER OF SACRAL (coccyx) REGION, STAGE 4 11.ESSENTIAL (PRIMARY) HYPERTENSION [high blood pressure] 12. UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE JJ. Record review of R #3's physician orders dated [DATE] revealed, Healing Stage IV [4] pressure ulcer to coccyx: cleanse with wound cleanser/NS [normal saline], pat dry, apply skin-prep to peri wound area, apply medihoney saturated 2X2 [2 by 2] directly to wound bed and cover with moisture resistant wound dressing. Change dressing twice daily. KK. Record review of R #3's skin integrity report dated [DATE] revealed R #3 had a healing stage 2 pressure ulcer located on her coccyx. No other skin issues/wounds were documented. LL. On [DATE] at 2:06 pm during a wound care observation, a bandage was discovered on R #3's right lower extremity (RLE). R #3's RLE bandage was dated [DATE]. R #3's RLE abrasion (an area damaged) was observed to be red. MM. Record review of R #3's progress notes date ,d+[DATE]-[DATE] revealed no progress note indicating abrasion to R #3's RLE prior to wound care observation with surveyor. NN. On [DATE] at 2:08 pm during an interview with LPN #3, she confirmed R #3's RLE bandage dated [DATE] was not reported or documented, and LPN #3 was unaware of R #3's new skin issue. OO. On [DATE] at 2:09 pm during an interview with R #3, she stated her RLE abrasion was burning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	PP. On [DATE] at 4:14 pm during an interview with the DON, he stated, A change of condition would be indicated and something should be documented. I [recently] found out about the one [R #3's new skin issue on [DATE]] and I need to review. DON confirmed he was unaware of R #3's new skin abrasion prior to , d+[DATE], and R #3's RLE abrasion dated [DATE] should have been documented and reported, but it was not. 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 1:51 pm with the facility Administrator (ADM). A Plan of Removal was received and accepted on [DATE] at 8:28 am. Based on this Plan of Removal, the interventions included: 1. On [DATE] the Nursing team initiated a whole house resident skin sweep to identify any not previously documented skin integrity issues. Any identified issues will be corrected immediately, any new wounds will have a full assessment by the wound nurse and a treatment initiated per facility DIMES (consistent and evidence based approach to wound healing) and treatments will be accessed for appropriateness. 2. Center Nurses will be re-educated by the Skin Health Team Lead beginning [DATE] regarding their responsibility regarding wound basics, wound evaluation, wound treatments, and documentation. 3. The Skin Health Team Lead/UM (Unit Manager)/designee will ensure center staff that have not completed (training)/re-education will receive the training described above prior to the next work shift. The Skin Health Team Lead/UM/designee will ensure licensed nursing staff that have not completed re-education will receive the training and competency described above prior to beginning of next work shift. 4. The DON and or designees will review progress notes during morning clinical for appropriate documentation and provide education to the nurses as identified. 5. The DON/UM/or designee will audit the TAR for completion of wound care daily and perform a random spot check of wounds documented as completed for appropriate dating of dressing related to said wound care. This shall be done daily for 7 days, then 3 times per week for 3 weeks, then weekly for 2 months. 6. The Skin Team Health Lead/DON will be responsible for the skin integrity process in the center and to make sure assessments, communications and treatments are documented. 7. An Ad Hoc [as needed] QAPI [Quality Assurance Performance Improvement] Meeting will be held on [DATE] to approve the above plan. 8. The DON [Director of Nursing]/designee and the Administrator/designee will bring the results of the audits to the QAPI committee for tracking, trending and further recommendations to ensure compliance with plan. The audits will be brought to the QAPI committee for 3 months. The Administrator will oversee the QAPI committee (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	34439

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46064 Based on record review and interview, the facility failed to ensure that residents receive a well-balanced diet that meets nutritional needs for all 111 residents residing in the facility. If the facility is not ensuring that all residents are receiving a well-balanced diet, then residents are likely to not receive the appropriate nutrition. The findings are: A. Record review of the facility menu (week at a glance) revealed 2% milk is to be served with every meal listed on the menu for each resident. Including Breakfast, lunch and dinner B. On 09/23/22 at 11:28 am during an interview with Dietary Manager (DM) he stated that milk is only served with breakfast and is available upon request for lunch and dinner. He further stated that serving milk at every meal would be a waste. He also stated that he would have to talk to management about increasing his budget to include milk for all residents and all meals. C. On 09/23/22 at 11:35 am during an interview with the Registered Dietitian (RD) she stated that the expectation is that milk/or alternate milk product be served with every meal. She further stated that the milk is part of the total caloric count for each meal and any revisions need to be approved by her and she was not aware that milk/milk alternative was not being served at every meal.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on observation, interview, and record review, the facility failed to serve food to 1 of (R #7) of 1 (R#7) resident that was at the appropriate temperature during in room meal service. This deficient practice is likely to cause residents to refuse to eat, cause weight loss, and other health complications. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and currently resident in room [ROOM NUMBER]-A. B. On 09/22/22 at 12:56 pm, during observation of room tray delivery the Dietary Manager did a temperature check of the of last tray passed out on hall 1. The temperature of the chicken was found to be 127.2 F (Degrees Fahrenheit), (hot food should be above 135 F) he did not check anything else on the tray. He then told the CNA (Certified Nurse Assistant) she could serve it to R #1. C. On 09/23/22 at 11:28 am during an interview with the Dietary Manager, he confirmed that the food was served at the incorrect temperature.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview the facility failed to provide food that accommodates resident allergies, intolerance's, and preferences for 1 (R #6) of 1(R #6) resident's observed for food preferences by not serving milk. This deficient practice is likely to result in weight loss due to resident's not eating/drinking. The findings are: A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE]. B. Record review of R #6's meal ticket dated 09/19/22 revealed, Monday Lunch: 1 Ea [each]- Bean and Cheese Burrito w [with]/Flour Tortilla, 2 Tbsp [tablespoons]- Fresh Salsa, 1 Cup- Shredded Lettuce and Diced Tomatoes w/Vinaigrette, 1/2 Cup- Seasonal Mixed Fruit, 4 Oz [ounce]- 2% [percent] milk, and 6 Oz- Assorted Beverage. C. On 09/19/22 at 12:01 pm during a lunch observation, R #6 was observed not being served milk with her lunch. R #6 stated, I'm missing things on my tray and I really want the milk. D. On 09/19/22 at 12:07 pm during an interview with Certified Nursing Assistant (CNA) #3, she stated, They [dietary staff] don't send milk with the lunch. It's on the tickets, but residents will have to request it. CNA #3 confirmed R #6's meal ticket stated milk but no milk was served to R #6. E. On 09/23/22 at 11:41 am during an interview with the Dietary Manager (DM), he stated, What I was told was residents were returning milk [during lunch and dinner services] that did not want milk. If that's what I need to do [provide milk with lunch and dinner], I will do it. DM confirmed residents are not served milk with lunch and dinner service. F. On 09/23/22 at 11:47 am during an interview with the Registered Dietitian (RD), she stated, Each meal is broken down with nutrients [including beverages served]. I was not aware of that [facility not serving milk with lunch and dinner service as stated on the meal tickets]. I would want to know why [milk was not being served with lunch and meal service].

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure that 1 (R #4) of 2 (R #'s 3 and 4) residents received care and treatment that met the resident's needs by not documenting or reporting bruises present on R #4's abdomen (stomach). If the facility fails to provide the highest level of care to it's residents, then residents physical, mental, and psychosocial well being may decline. The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: 1. PARKINSON'S DISEASE (disorder of the central nervous system that affects movement) 2. UNSPECIFIED FRACTURE OF SHAFT OF LEFT FIBULA, SUBSEQUENT (broken left leg) ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING 3. CHRONIC OBSTRUCTIVE PULMONARY DISEASE [a group of lung diseases that block airflow and make it difficult to breathe], UNSPECIFIED 4. UNSPECIFIED CONVULSIONS [a sudden, violent, irregular movement of limb or body] 5. MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED 6. TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY [weakness, numbness, and pain from nerve damage], UNSPECIFIED 7. ESSENTIAL (PRIMARY) HYPERTENSION [high blood pressure] 8. BENIGN PROSTATIC HYPERPLASIA [prostate gland enlargement] WITHOUT LOWER URINARY TRACT SYMPTOMS 9. PAROXYSMAL ATRIAL FIBRILLATION [irregular, rapid heart rate] 10. OBSTRUCTIVE AND REFLUX UROPATHY [urinary tract blockage], UNSPECIFIED 11. EPILEPSY [disturbed brain nerve cell activity causing seizures], UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS [a seizure lasting longer than 5 minutes or more than 1 seizure in a 5 minute period] 12. REPEATED FALLS 13. CELLULITIS [bacterial skin infection], UNSPECIFIED 14. UNSPECIFIED FALL, SUBSEQUENT ENCOUNTER (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. PERSONAL HISTORY OF COVID-19 [deadly respiratory virus] 16. OTHER HYPERTROPHIC CARDIOMYOPATHY [a condition in which the heart muscle becomes abnormally thick] 17. CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE [chronic condition which the heart doesn't pump blood as well as it should] 18. MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, UNSPECIFIED SITE 19. MUSCLE WEAKNESS (GENERALIZED) 20. UNSTEADINESS ON FEET 21. OTHER ABNORMALITIES OF GAIT AND MOBILITY 22. PAIN, UNSPECIFIED 23. HISTORY OF FALLING 24. HYPOTHYROIDISM [thyroid gland doesn't produce enough thyroid hormone], UNSPECIFIED 25. ANXIETY DISORDER, UNSPECIFIED 26. INSOMNIA [common sleep disorder making it difficult to fall asleep], UNSPECIFIED B. Record review of R #4's physician orders dated 07/18/22 revealed, Enoxaparin Sodium [Lovenox] Solution Prefilled Syringe 40 MG [milligram]/0.4ML [milliliter] Inject 40 mg subcutaneously at bedtime for dvt [deep vein thrombosis-a blot clot in a deep vein, usually in the legs] ppx [prophylaxis]. Lovenox was discontinued on 09/06/22. C. Record review of R #4's weekly bath and skin report dated 09/08/22 revealed, Redness Rash- abd [abdominal] folds. No bruising documented. D. Record review of R #4's report of Nurse Practitioner consultation dated 09/09/22 revealed, Bruising. E. Record review of R #4's skin integrity report dated 09/11/22 revealed, Redness to groin, no open areas. No documentation of bruising was noted. F. Record review of R #4's weekly bath and skin report dated 09/13/22 revealed, Redness Rash- scrotum (the sac) redness. No bruising documented. G. Record review of R #4's weekly bath and skin report dated 09/20/22 revealed no bruising documented. (continued on next page)

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	09/23/2022

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #4's anatomy-physiology skin report dated 09/22/22 revealed, Multiple bruises bilat [bilateral] U/LE [upper left extremity] healing stages vary, huge bruises abdomen, redness scrotum. I. Record review of facility wide wound report dated 09/23/22 revealed, skin check done. No documentation of bruising noted. J. On 09/23/22 at 12:48 pm during an interview with the Clinical Lead Specialist (CLS), she stated, The bruises [for R #4] are there [on R #4's abdomen]. They [R #4's abdominal bruises] should have been identified on the skin sweep [conducted] on 09/11/22, or prior. He [R #4] said they [abdominal bruises] were from the Lovenox and he said he got Lovenox about two weeks ago. We're doing the [state] reportable. I was told that we [facility] didn't have anything new [for wounds]. There is a wound portal that they [nursing] should be documenting on. That is a part of the education. We have no documentation of the [R #4's] bruising. CLS confirmed R #4 was observed to have unidentified bruising on his abdomen that was not identified prior to the skin sweep on 09/23/22. K. On 09/23/22 at 12:59 pm during an interview with the Director of Nursing (DON), he stated, His [R #4's] abdominal stuff [bruises] is faded purple. DON confirmed R #4 currently had bruises that were not documented. L. On 09/23/22 at 1:47 pm during an interview with CLS, she stated, We're going to treat it [R #4's abdominal bruises] likes it new. CLS confirmed R #4's were not documented prior to the 09/22-09/23/22 facility wide skin wound sweep. CLS confirmed nursing staff still did not document R #4's abdominal bruises after the 09/22-09/23/22 facility wide skin wound sweep and should have.