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	11/15/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents) for 1(R #3) of 3 (R #'s 2, 3 and 4) resident reviewed. If the MDS assessment is inaccurate, then residents are likely to not receive the services they need or have an accurate record of the services needed and received. The findings are: A. Record review of R #3's Face Sheet dated 09/11/24, revealed R #3's an initial admitted and included the following diagnoses: -Sepsis (an infection of the blood stream,), -Urinary tract infection (infection of any part of the urinary system), infection and inflammatory reaction due to indwelling urethral catheter (a thin flexible tube that is inserted into the bladder when there is an issue with voiding urine), -Benign prostatic hyperplasia (condition in which an overgrowth of prostate [organ in male reproductive system]) with lower urinary tract symptoms, -Obstruction and reflux uropathy (occurs when the urine flow is blocked). B. Record review of R #3's admission physician order, dated 09/11/24, revealed the order did not have any indication that R #3 was admitted to the facility with an indwelling catheter. C. Record review of R #3's Nursing Admission assessment dated [DATE], revealed R #3 was not admitted with an indwelling catheter and that R #3 was continent of bladder. D. Record review of R #3's admission Minimum Data Set (MDS) assessment dated [DATE], section H - Bowel and Bladder, revealed R #3 was admitted to the facility with an indwelling catheter and urinary continence had not been rated because the resident had a catheter. E. Record review of R #3's discharge MDS assessment dated [DATE], section H - Bowel and Bladder, revealed R #3 had an indwelling catheter and that urinary continence was not rated because the resident had a catheter. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Record review of R #3's nursing progress notes revealed the following:- 09/12/24 at 5:26 am - Resident wants Foley catheter (a thin flexible tube that is inserted into the bladder when there is an issue with voiding urine) back in, he had a catheter for over a year and he feels that it's needed, doesn't understand why it was discontinued but bladder scan q2 (twice) with no output because he drank very little but did drink two cups of milk at 20 minutes ago - 09/12/24 at 7:59 am - Resident went AMA (Against Medical Advice) with wife at 7:56 am. Per resident want's Foley catheter put back in. Resident's bladder scans show resident is not retaining. Last bladder scan at 6:15 am showed 0 ml (milliliters) . resident was educated on voiding trial, resident refused and insisted on going AMA. G. On 11/15/24 at 9:15 am during an interview with the Director of Nursing (DON), she stated R #3 did not have a Foley catheter on admission, she stated that he had one while in the hospital but it was removed at the hospital and there were no orders at admission for R #3 to have a catheter. H. On 11/15/24 at 10:20 am during an interview, the DON stated that the admission and discharge MDS assessment were incorrect because R #3 did not have a catheter when he was admitted . She further stated that she would expect the information in the MDS, the Nursing Admission Assessment, and the Hospital Discharge documentation to match.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 50752 Past Noncompliance Based on record review and interview, the facility failed to ensure that bathing/showering assistance was provided for 1 (R #1) of 1 (R #1) resident reviewed for ADLs (activities of daily living). This deficient practice could likely result in residents in need of this specialized care experiencing a decline in their ability to perform hygiene tasks and maintain good personal hygiene. The findings are: A. Record review of R #1's face sheet dated 10/02/23 revealed this as R #1's an initial admitted with the following list of diagnoses: -Unspecified dementia, (a group of symptoms dealing with affecting memory, thinking and abilities). -Unspecified urinary incontinence, (loss of bladder control). -Chronic respiratory failure with hypoxia, (low oxygen in the blood). -Nonrheumatic aortic (valve) stenosis (narrowing of the aortic valve). B. Record review of R #1's shower tracking sheet provided by the Director of Nursing (DON) revealed that the shower days for R #1 are scheduled for Mondays and Thursdays. The shower sheets also revealed that R #1 had not had a shower from 07/11/24 through 08/11/24. C. Record review of R #1's shower tracking log, provided by the DON, dated 07/01/24 through 08/31/24 revealed one documented refusal on 07/18/24 at 14:59 (02:59 pm). D. Record review of R #1's shower tracking logs, provided by the DON, revealed on 07/15/24, 07/29/24, and 08/01/24, staff documented not applicable. E. Record review of R #1's shower tracking logs, provided by the DON, revealed staff did not document that showers were completed for the following dates 7/22/24, 07/25/24, 08/05/24, and 08/08/24. F. On 11/15/24 at 8:31 am, during an interview with DON, she stated the facility had put in the new system to ensure that residents are getting showers. CNAs must fill out the new shower sheets, hand them to the nurse to sign, and then turn them into the unit manager for review. For any refusals, the resident and the nurse must sign off. DON stated there was a daily audit that the showers are being done. Showers are given every two days, and if the resident asks for a third day, we can provide them with another day. G. On 11/15/24 at 8:40 am, during an interview with DON she stated she took the new shower system through Quality Assurance/Performance Improvement (QAPI) on 10/01/24. The unit managers monitor the system daily and report to the DON to ensure that residents are showered on their scheduled days and to monitor when residents are refusing so this can be addressed promptly.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40671 Based on observation, record review, and interview, the facility failed to ensure that residents receive their meals in accordance with the menu schedule for 2 (R #'s 2, and 5) of 3 (R #'s 2, 4 and 5) residents reviewed during meal observations. If the facility is not ensuring that meals are served timely as scheduled, then residents are likely to be at risk of malnutrition and frustration. The findings are: A. Record review of the Facility's Meal Schedule revealed, Breakfast: 7:15 am, Lunch: 12:00 pm, and Dinner: 5:15 pm. B. On 11/14/24 during a meal schedule observation revealed a lunch meal cart was delivered to one hall at 1:12 pm and another lunch meal cart was delivered to the neighboring hall at 1:27 pm. R #'s 2 and 3 were roommates, R #2 received one lunch meal tray at 1:28 pm, R #3 did not receive a lunch meal tray until 1:43 pm. C. On 11/14/24 at 1:36 pm during an interview with the Director of Nursing, she stated that the kitchen forgot to send a lunch tray for R #3 and that this does happen often. She further stated that meals are often served late. D. On 11/14/24 at 1:50 pm during an interview, Dietary Staff #1 stated that room meal trays are sent out to the halls after residents in the dining room have been served, and the times that the room meal trays are delivered vary depending on whether the kitchen is backed up or not. E. On 11/15/24 at 1:43 pm during an observation and interview revealed, R #5's lunch meal tray was delivered to her room. R #5 stated that her meals are always delivered late. R #5 further stated that there have been times staff forget to send her meals and have delivered an empty plate to her. [She was unable to recall how many times or when the last time she was delivered an empty plate.]