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	06/06/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement a complete baseline care plan within 48 hours of admission for 1 (R #3) of 1 (R #3) resident. If the facility fails to implement a complete baseline care plan within 48 hours of admission for residents with complex needs and high fall risk, then staff may lack necessary guidance to prevent injury, resulting in avoidable harm such as serious falls, hospital transfers, and worsening of clinical status. The findings are: A. Record review of R #3's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: - Nontraumatic acute subdural hemorrhage (leakage of blood between the membranes of the brain), - Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body); - Generalized muscle weakness; - History of transient ischemic attack (TIA; mini stroke). B. Record review of R #3's Fall Risk Assessment, dated 05/08/25, revealed R #3 had a fall risk score greater than 10, high risk. The resident's risk factors included incontinence (loss of bladder and/or bowel control), impaired gait (deviation from normal walking) and balance, recent hospitalization, and presence of predisposing conditions (increased risk of a particular disease, injury or physical or mental illness), such as cerebrovascular accident (CVA; stroke) and arthritis. C. Record review of R #3's baseline care plan, dated 05/08/25, revealed the care plan did not address the following: - Initials goals based on admission orders; - Physician orders, - Dietary orders, (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Therapy services, - Social services, - R #3's fall risk, fall prevention interventions, assistance needs related to activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating), bed mobility, or call light use. - The resident's care plan only addressed her personal interests, such as reading, music, and exercise. D. Record review of R #3's progress notes revealed the following: - Dated 05/09/25, R #3 had diagnosis of bilateral subdural hematomas (leakage of blood between membranes of the brain). The Director of Nursing (DON) documented R #3 was lethargic (sluggish, fatigued), and her son was concerned about her bleeding risks and supervision needs. - Dated 05/11/25, The resident had a fall. Staff noted the fall as non-witnessed and stated the resident was found on the floor around 4:00 AM. R #3 was transported to the emergency room (ER). The note did not contain documentation, staff reviewed or revised R #3's baseline care plan following the fall. - Dated 05/12/25, an interdisciplinary team (IDT; includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, resident or resident representative, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident) documented R #3 was unable to use the call light independently and required repositioning by staff. The note did not contain documentation staff reviewed or revised R #3's baseline care plan to reflect the interventions for these identified deficits. E. On 06/05/25 at 2:22 p.m., during an interview, R #3's son stated he spoke to the facility nurses about his concerns about his mother's fall risk due to sedation and weakness, and he requested bed rails. He stated he received a call from the facility on 05/11/25, and staff stated his mother fell out of bed. He stated he warned staff previously about the height of his mother's bed and her inability to move independently. R #3's son stated his mother went to the emergency room after her fall on 05/11/25. He stated his mother did not return to the facility when she left the emergency room, and she went home with him. F. On 06/06/25 at 9:20 a.m., during an interview, the Unit Manager (UM) stated R #3 was a fall risk. She stated fall risk status would generally be addressed in the resident's care plan so staff could implement interventions such as beds in a low position, routine rounds to ensure proper bed positioning, and additional interventions such as scheduled toileting and fall mats as needed. She stated it was her expectation R #3 would have a complete baseline care plan within 48 hours of admission. The UM stated she was not aware the resident did not have a complete baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 06/06/25 at 9:57 a.m., during an interview, the Administrator stated it was her expectation staff would create a baseline care plan for R #3 within 48 hours of admission. She reviewed R #3's medical record and stated the resident did not have a baseline care plan within 48 hours which included the required information. The Administrator stated she was responsible to ensure the residents had a baseline care plan within 48 hours of admission. H. On 06/06/25 at 10:30 a.m., during an interview, the DON stated R #3 was admitted from the hospital with a diagnosis of a brain bleed (subdural hemorrhage) and required maximum assistance for mobility. The DON stated the resident needed frequent checks and repositioning. She stated she received a call from the night shift staff on 05/11/25, and staff reported R #3 fell. The DON stated she did not consider R #3 to be a significant fall risk at the time, but a fall risk score higher than 9 indicated a high risk for falls. She stated a fall risk score of 9 should have prompted staff to care plan the resident's risk of falls. The DON stated staff should have created a complete baseline care plan for R #3 within 48 hours of admission. She stated she was not aware the resident did not have a complete baseline care plan.