

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Rio Rancho Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure staff utilized enhanced barrier precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) for 1 (R #2) of 1 (R #2) resident who required additional infection prevention measures due to open wounds. This deficient practice had the potential to increase the risk for the transmission of infectious organisms to staff and other residents. The findings are: A. Record review of the facility's Policy Enhanced Barrier Precautions policy, revised 12/16/24, revealed EBP was an infection control intervention to reduce the transmission of multidrug-resistant organism (MDRO; a germ that is resistant to many antibiotics). It required targeted Personal Protective Equipment (PPE; gown and gloves) use during high-contact resident activities such as dressing, bathing, hygiene, and transfers. B. Record review of R #2's face sheet revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:-Encephalopathy (a degenerative brain disease that alters brain function or structure),-Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), -Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). C. Record review of R #2's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/15/25, revealed the following:- Dependent on staff for all activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating);- Multiple pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin).- Required total assistance with hygiene and toileting. D. Record review of R #2's wound documentation, dated 07/08/25, revealed a facility-acquired Stage 2 (partial thickness loss of skin presenting as a shallow, open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) sacral ulcer (the portion of the spine between the lower back and the tailbone). E. Record review of R #2's hospital admission documentation, dated 09/10/25, revealed the resident was admitted with multiple unstageable pressure injuries (heel, hip, midfoot, buttocks), dehydration, and contractures (a shortening of muscles around joints causing joint stiffness and immobility). F. On 09/11/25 at 11:46 a.m., during an observation of staff providing incontinent care (loss of bladder or bowel control) for R #2, staff provided perineal care (the area between the genitals and the anus) and repositioned the resident without putting on a gown and gloves. G. On 09/11/25 at 1:30 p.m., during an interview, Licensed Practical Nurse (LPN) #1 stated R #2 had multiple wounds, was dependent for all ADLs, and required frequent incontinence and wound care. The LPN #1 stated staff do not always use gowns and gloves during routine care unless the resident was on isolation precautions. LPN #1 stated she was aware EBP required gown and glove use for residents with open wounds or devices. She stated staff usually only wear gloves, unless the wound was draining a lot. H. On 09/11/25 at 2:45 p.m., during an interview, the Director of Nursing (DON) stated staff were expected to follow the EBP policy, but compliance may not always be consistent. The DON stated some staff skipped putting on gown and gloves to complete the task quickly when a resident became agitated or resisted care. The DON stated it was her expectation for staff to use all PPE when they assisted a resident with personal care.</p>		