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	03/10/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation and interview, the facility failed to provide reasonable accommodations of needs and preferences for 3 (R #25, #26 and #27) of 3 (R #25, #26 and #27) residents observed for call light access, when:The call light was outreach and for R #'s 25, 26, and 27. This deficient practice is likely to result in residents not being able to notify staff when they are in need of assistance.The findings are: A. On 03/10/26 at 10:52 am, during an observation, R #25 was observed sitting in bed and he appeared to be uncomfortable while calling for staff. R #25's call light was located on the floor behind R #25's bed, and out of reach for R #25. R #25 confirmed he could not reach his call light. B. On 03/10/26 at 10:54 am, during an observation, R #26 was observed sitting in bed watching tv. R #26's call light was observed to be on the floor, under the bed, and out of reach for R #26. C. On 03/10/26 at 11:02 am, during an interview, Certified Nursing Assistant (CNA) #3 confirmed call lights should always be within reach for the residents. CNA #3 confirmed the call light for R #25 and R #26 were not within reach for each resident and should have been. D. On 03/11/26 at 12:47 pm, during an observation, R #27 was observed lying in bed. R #27's call light was located under R #27's bed, and not within reach for R #27. E. On 03/11/26 at 1:05 pm, during an interview CNA #3, confirmed the call light for R #27 was on the floor and should be within reach of the resident. She stated if the call light was not in reach, it could cause a resident to fall. F. On 03/11/26 at 3:40 pm, during an interview, the Unit Manager (UM) #1 stated staff are responsible for making sure the call lights are within reach of the residents. She stated the call lights for R #'s 25, 26, and 27 should be within reach, and was not.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure resident property was protected from misappropriation (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) for 1 (R #2) of 1 (R #2) resident reviewed for misappropriation of resident funds. If the facility fails to ensure resident property is protected from misappropriation, then residents are at risk for unauthorized use of personal funds, financial exploitation, and potential financial loss. The findings are: A. Record review of R #2's face sheet revealed the resident was admitted into the facility on [DATE] with the following diagnosis: Failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others), discharge date : [DATE] (death in the facility). B. Record review of R #2's bank statement revealed the following processed transactions: Dated [DATE]: $22.88 (22 dollars and 88 cents) was spent at Restaurant #1, Dated [DATE]: $107.61 was spent at Grocery Store #1, Dated [DATE]: $39.52 was spent at Drug Store #1, Dated [DATE]: $8.39 was spent at Coffee Shop # 1, Dated [DATE]: $26.18 was spent at Donut Shop # 1,Dated [DATE]: $35.00 was spent at Restaurant #1Dated [DATE]: $40.20 was spent at Drug Store #1,Dated [DATE]: $53.88 was spent at Drug Store #1, Dated [DATE]: $54.57 was spent at the Dry Cleaners. C. On [DATE] at 9:49 AM, during an interview, R #2's daughter stated after her mother (R #2) passed away (died) on [DATE], she discovered multiple unauthorized charges on R #2's debit card (a plastic card issued by a bank that lets a person spend money directly from their checking account). She stated she went to the bank to review the account and confirmed the charges began on the day of R #2's death. R #2's daughter stated she filed a police report regarding the transaction. She stated the facility was contacted, and video footage confirmed the facility employee involved in the unauthorized use of R #2's debit card. R #2's daughter also stated after the facility reviewed the video, they confirmed it was a previous facility employee that was using R #2's debit card. D. On [DATE] at 1:42 PM, during an interview, the Administrator (AD) stated on [DATE], R #2's family reported unauthorized use of a debit card. She stated the incident was reported to the state and an investigation was initiated with local law enforcement. The ADM stated the police obtained video surveillance of a facility employee using R #2's debit card and sent the video to the facility on [DATE]. The ADM confirmed a facility employee used R #2's debit card after R #2's death and that should not have happened.

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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** Based on observation, record review, and interview, the facility failed to provide quality care that meets professional standards for 1 (R #1) of 1 (R #1) residents reviewed, when staff: Administered oxygen (O2) to R #1 without a physician's order.This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider, and potential respiratory complications. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: Chronic systolic congestive heart failure (a longˆterm condition where the heart's left ventricle is too weak to pump blood out effectively), Chronic obstructive pulmonary disease (lung disease). B. Record review of R #1's nursing progress notes revealed the following: Dated 01/11/26: R #1 was provided O2 via nasal cannula (NC; a small, flexible tube that delivers oxygen to the nose through soft prongs), Dated 02/20/26: R #1 was provided O2 via NC.,Dated 02/23/26: R #1 was provided O2 via NC. C. Record review of R #1's electronic health record (EHR), dated 03/09/26, revealed R #1 did not have past or present physician orders for O2 use. D. On 03/09/26 at 11:11 AM, during an observation of R #1's room, revealed the following: O2 concentrator (a device that takes air from the room and turns it into oxygen for resident use) with a nasal cannula attached, Portable O2 tank (a small device that provides portable oxygen for resident use). E. On 03/09/26 at 11:19 AM, during an interview, R #1 stated he uses O2 when he has difficulty breathing. F. On 03/10/26 at 10:36 AM, during an interview, the Unit Manager (UM #1) stated all residents who need supplemental O2 should have a physician's order for PRN (as needed) or continuous (uninterrupted rate) O2 use. The UM #1 stated residents using O2 without physician's orders may receive the wrong amount of O2, making them hypoxic (a condition where parts of the body do not receive adequate oxygen). The UM #1 confirmed R #1 did not have physician orders for O2 use and should have. G. On 03/10/26 at 3:15 PM, during an interview, the Administrator (AD) stated it was her expectation all residents who require supplemental O2 have a valid physician's order. She stated residents who receive O2 without a physician's order could receive the wrong treatment, posing a risk to their safety and health.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to prevent a significant medication error for 1(R #1) of 1(R #1) resident reviewed, when: The facility did not have R #1's medications readily available, which prevented administration per physician orders. If the facility does not have resident's medications readily available, then residents are likely to receive incorrect or missed medication doses, which could potentially result in serious harm. The findings are: A. Record review of the facility Medication Administration Policy, dated 01/01/04, revealed the following: Appropriate interventions will be implemented for medication errors identified, The facility shall ensure medications are administered according to prescriber orders. B. Record review of R #1's face sheet revealed the resident was admitted into the facility on [DATE] with the following diagnosis: Femur Fracture (break in the thigh bone). C. Record review of R #1's Physician Orders dated 10/28/25, revealed the following: Eltrombopag Olamine (medication that stimulates platelets (cell fragments made in the bone marrow), production in the blood) Oral Tablet 50 milligrams (MG), Give 1 tablet by mouth one time a day for low platelets. Please order (more of the medication) when only 10 tablets are left. D. Record review of R #1's Medication Administration Records (MAR), revealed Eltrombopag Olamine was not administered for the following dates: 12/10/25 through12/27/25, 01/29/26 through 01/31/26, 02/17/26 through 02/20/26, 03/05/26 through 03/09/26. E. Record review of R #1's nursing progress notes revealed the following: Dated 12/20/25: Eltrombopag Olamine Oral Tablet 50 MG, waiting on delivery (to the facility), Dated 12/22/25: Eltrombopag Olamine Tablet 50 MG was not in stock, Dated 01/30/26: R #1 did not receive Eltrombopag Olamine Oral Tablet 50 MG, Dated 01/31/26: Eltrombopag Olamine is expected to arrive by Monday (02/02/26). Medical Director (MD) was notified regarding this matter and the Unit Manager (UM) notified, Dated 03/05/26: Eltrombopag Olamine Oral Tablet 50 MG was not available in the facility,Dated 03/08/26 Eltrombopag Olamine Oral Tablet 50 MG was not available in the facility, Dated 03/09/26 Eltrombopag Olamine Oral Tablet 50 MG was not available in the facility. F. On 03/09/26 at 10:45 AM, during an interview, R #1 stated he had not received his Eltrombopag Olamine medication for the past few days. He stated this had occurred multiple times previously and he would like to take his prescribed medications. G. On 03/09/26 at 3:01 PM, during an interview, the Unit Manager (UM) #2 stated R #1 had missed several dosages of Eltrombopag Olamine because the medication had not yet arrived at the facility. She stated this was not the first time R #1's medication had been unavailable. UM #2 stated the Medical Director had been informed of the recent missed medication dosages for R #1. She stated it was her expectation all residents have their medications as ordered. H. On 03/09/2026 at 3:15 PM, during an interview, the Registered Nurse (RN #1) stated it was her expectation all residents receive their medications as ordered. She stated if R #1 did not receive the Eltrombopag Olamine medication, there could be issues related to platelet function in the event of bleeding. I. On 03/10/2026 at 2:08 PM, during an interview, the Medical Director (MD) stated he was aware of issues with the R #1 not receiving his medication as ordered. He stated the medication is prescribed through a specialty pharmacy and was maintained for chronic thrombocytopenia (low blood platelet count). The MD stated he had occasionally been informed when the resident did not receive the medication, and delays occurred because refills take a week or more to be processed. He stated he believes the issue was a consistency problem with ordering, as different staff have been responsible and there has not been one person consistently ensuring the medication arrives on time. The MD stated timely administration of Eltrombopag Olamine for R #1 was important to maintain platelet levels, and it is his expectation residents receive their medications as ordered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store and serve food under sanitary condition when staff.Failed to ensure food and beverage items in the North and South nutrition room refrigerators were labeled and dated. Failed to ensure expired foods were not stored in the North and South nutrition room refrigerators. This deficient practice is likely to affect all 112 residents listed on the resident census list provided by the Administrator on 03/09/26, and is likely lead to foodborne illnesses in residents if food is not being stored properly. The findings are: A. Record review of the facility food and nutrition services policy dated 05/01/23 revealed the following: Food and nutrition employees prepare, label, and date evening snacks including the use by date, Labels are affixed to each item and include the name of the resident, current date, (use by) date, Use by date is either added to the tray card label or on an additional label is used to indicate the use by date. Food and nutrition services employees inventory nurses station pantries at least daily and stock pantries with enough covered, labeled, and dated with use by dates. B. On 03/09/26 at 2:53 PM, observation of the south nutrition room, revealed the following: One pitcher filled with a pink-colored beverage was not labeled or dated and stored in the refrigerator. One pitcher filled with a purple-colored beverage was not labeled or dated and stored in the refrigerator. Eight pre-packaged peanut butter and jelly sandwiches dated 02/07/26 were stored in the refrigerator. Four pre-packaged turkey sandwiches dated 02/08/26 were stored in the refrigerator. Three Vital Cuisine nutritional supplement shakes (ready-to-drink drinks providing extra calories, protein, and vitamins) were dated 03/03/26 and stored in the refrigerator. Three small, pre-packaged containers containing strawberries was dated 03/05/26 and stored in the refrigerator. C. On 03/09/26 at 3:01 PM, observation of the north nutrition room, revealed the following: Six pre-packaged peanut butter and jelly sandwiches dated 02/07/26 were stored in the refrigerator. Two pre-packaged turkey sandwiches dated 02/08/26 were stored in the refrigerator. Two Vital Cuisine nutritional supplement shakes were dated 03/03/26 and stored in the refrigerator. Three, 4-ounce (oz) pre-packaged containers of chocolate pudding were not labeled and stored in the refrigerator. D. On 03/10/26 at 11:31 AM, during an interview, the Dietary Manager (DM) stated it was the responsibility of the Dietary Aides to deliver and check for expired resident snacks located in both nutrition rooms, three times daily. The DM confirmed expired food should be thrown away, and all food and beverage items should be labeled and dated. E. On 03/10/26 at 2:55 PM, during an interview, the Administrator (AD) stated it was her expectation residents do not receive or consume expired foods. She stated if residents consume expired foods, they could become ill.