STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325127	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites Rio Vista	2410 19th Street, 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39509 Based on record review and interview, the facility failed to report the allegations of possible neglect/abuse for 3 (R #'s 1, #2 and #3) of 3 (R #'s 1, #2 and # 3) residents reviewed for incidents. If the facility is not submitting the summary of the facility's investigation to the State Agency (SA), then the State Agency is unable to appropriately triage (review) the allegation for further investigation. The findings are: A. Refer to F0610 for related findings. B. On 02/12/25 at 2:30 pm during interview with Administrator (ADM), he stated he was aware of each of the allegations of neglect/abuse. He stated the incident with R #2 did not indicate any sexual contact occurred between Certified Nurse Aide (CNA) #1 and R #2, therefore, a report was not submitted to the state agency. He stated the medication errors involving R #1 and R #3 were reported and investigated within the facility. He stated that these investigations did not indicate to him that the incidents rose to the level of abuse, neglect or mistreatment. The ADM further stated that he generally over-reports facility incidents to the state agency but in these three cases he did not report.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER: The Suites Rio Vista		STREET ADDRESS, CITY, STATE, ZIP CODE: 2410 19th Street, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 39509 Based on record review and interview, the facility failed to complete a thorough investigation and report the investigation findings within five working days for allegations of abuse and mistreatment for 3 (R #'s 1, 2, and 3) of 5 (R #'s 1, 2, 3, 4, and 5) residents reviewed for incidents. If the facility is not completing an accurate and thorough investigations and submitting the summary of the facility's investigation to the State Agency, then the State Agency (SA) is unable to appropriately review allegations for further investigation. The findings are: R #1 A. Record review of New Mexico Health Care Authority Complaints revealed a complaint dated 01/02/25, which alleges possible neglect, a medication error which involves R #1. B. Record review of R #1's daily progress notes revealed a note dated 12/26/24 at 12:50 pm that stated a medication error occurred when nurse gave Imatinib (an oral medication prescribed to treat certain kinds of cancer) and Creon (an oral medication prescribed to replace pancreatic enzymes (chemicals that break down other chemicals)) to the wrong resident (R #1). The note further stated R #1 swallowed the medications and began choking and coughing. Emergency services were called to the scene and the facility doctor was also called to the scene to assess and assist the resident. One of the medications was eventually coughed up and R #1 was assessed and determined to be in need of no further care except to continue to monitor. C. Record review of the facility's reportable incidents dated 02/12/25, revealed the record did not contain any documentation of the medication error incident, the incident being reported to the state agency, and the facility investigating the incident. R #2 D. Record review New Mexico Health Care Authority Complaints revealed a complaint dated 01/16/25, a consumer complaint which alleged possible abuse-sexual misconduct of a staff member towards R #2. E. Record review of R #2's daily progress notes dated 12/01/24 through 01/31/25, revealed the notes did not contain any documentation of any possible abuse-sexual misconduct of a staff towards R #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER The Suites Rio Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 2410 19th Street, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	F. On 02/12/25 at 9:30 am during interview with Assistant Director of Nursing (ADON) #2, he stated he recalled an incident involving R #2 and a facility Certified Nurses Aide (CNA) #1 that occurred on 01/08/25 at 11:30 pm pertaining to abuse-sexual misconduct. ADON #2 provided a written statement that he had prepared on the day of the incident. ADON #2 stated the written statement had also been provided to the facility administrator on 01/09/25. ADON #2 stated that R #2 had fallen from his wheelchair earlier in the evening (01/08/25). He stated that he asked CNA #1 to go to R #2's room and take vital signs (VS: Blood Pressure, Pulse, Heart Rate). ADON #2 stated that he entered the room as CNA #1 was taking VS's. He stated he observed R #2 was lying on his bed. CNA #1 was sitting on the bed in very close contact to R #2 as she was taking his vital signs. ADON #2 stated that after completing the VS task, he spoke with CNA #1 outside of the room and verbally reprimanded her that it was inappropriate to be sitting on the bed in close physical contact with the resident for any reason. ADON #2 stated about 15 minutes later (11:45 pm), he came to check on R #2, entered the room and found CNA #1 was again sitting on R #2's bed in very close physical contact. ADON #2 stated he reprimanded CNA #1 again and told her she should not be in such close personal contact with any resident. He stated he then called the facility Director of Nursing to inform her of the incidents and his attempts to reprimand CNA #1. ADON #2 stated it was then decided that CNA #1 would be moved to another separate area of the facility and would not be allowed to return to and work in the same area as R #2 and CNA #1 was not to have any contact with R #2 again. G. Record review of the facility's reportable incidents dated 11/01/24 through 02/11/25, revealed the record did not contain any documentation of R #2 incident,the incident being reported to the state agency, and the facility investigating the incident. R #3 H. Record review of the facility's provided grievances dated 12/01/24 through 02/12/25 revealed a grievance dated 01/03/25 by R #3 stated that a medication error occurred. I. Record review of R #3's daily progress notes dated 01/03/25 at 12:17 pm, revealed R #3 was given a cup of medications by the nurse. The cup contained R #3's medications and also included Levothyroxine (a medication prescribed by to treat thyroid deficiencies) and protonix (a medication prescribed to treat excess stomach acid). J. On 02/12/25 at 12:40 pm ADON #1 stated he was aware of the grievance submitted by R #3 regarding a medication error. ADON #1 stated he investigated the matter immediately, noted that the medication error had occurred, reported the medication error to the administrator, took immediate action to re-educate the nurse who committed the medication error and took steps to re-educate all nursing staff of medication administration protocols and requirements. K. On 02/12/25 at 2:30 pm during interview with Administrator (ADM), he stated he was aware of each of the investigations reported, (2 medication errors and one possible sexual abuse incident). He stated R #2's incident did not indicate that any sexual contact occurred between CNA #1 and R #2, therefore the incident report was not submitted to the state agency. Incident was not further investigated. He stated the medication errors involving R #1 and R #3 were reported to him as well and investigated within the facility. He stated that these investigations did not indicate to him that the incidents rose to the level of abuse, neglect or mistreatment. The ADM further stated that he generally over-reports facility incidents to the state agency but in these three cases he did not report any of the incidents.