

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 04/25/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>40671</p> <p>Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 (R #1) of 3 (R #1, #2 and #3) residents reviewed for abuse when facility staff pushed R #1 back inside the facility and swatted (hit) his hands as the resident tried to exit to the parking lot. This deficient practice likely caused R #1 to feel unimportant and to fear staff. The findings are:</p> <p>Findings for R #1</p> <p>A. Record review of R #1's Face Sheet, dated 03/26/24, revealed this as an initial admitted and included the following diagnoses:</p> <ul style="list-style-type: none"> - Paraplegia (loss of voluntary muscle movement that affects the legs due to damage to the brain or spinal cord), - Depression (mood disorder that causes persistent feelings of sadness and loss of interest), - Post Traumatic Stress Disorder (PTSD; mental health condition that is caused by an extremely stressful or terrifying event). <p>B. Record review of the Facility's Reported Incident, dated 12/12/24, revealed R #1 called police to report abuse at about midnight when he was going out to the front parking lot, and a nurse refused to let him leave the building.</p> <p>C. Record review of the facility's Five Day Follow-Up Report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations), received by the State Agency on 12/19/24, revealed the nurse involved was an agency nurse and said she was trying to keep R #1 safe. Staff reviewed the security camera which showed the view from the lobby. R #1 grabbed at the door frames as the agency nurse tried to push the resident back into the lobby. The nurse swatted at the resident's hands to get him to release the door. The nurse gave up on preventing the resident from exiting the facility, and the resident propelled himself to the parking lot. Staff attempted to assess the resident, but he reported he did not have any injuries. The resident filed a police report. The facility substantiated the incident, because the nurse violated the resident when she slapped his hands.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 04/23/25 at 1:18 pm during an interview with R #1, he stated a couple of months ago a Certified Nurse Aide (CNA) would not let him leave the facility at night. He stated he was waiting for a food delivery when a nurse saw him outside, and the nurse tried to pull him back into the building. The resident stated he was able to grab onto the frame of the doorway. He stated the nurse called for help, and a bunch of the nurses showed up. He stated he called the cops, and the cops came out. R #1 stated he wanted to press charges for the nurse putting hands on him and dragging him inside the facility, but the police told him they could not do anything. The resident stated he felt scared and unsure of the staff. The resident continued to talk about suicide and ending his life. He stated he did not want to wake up another day in the facility.</p> <p>E. On 04/24/25 at 1:09 pm during an interview, the Administrator stated they had ongoing issues with R #1. He stated the facility investigated the incident regarding the agency nurse and R #1. He stated they reviewed the security camera footage and saw the nurse swat R #1's hands to get him to let go of the door frame. The Administrator stated they substantiated the complaint, and the nurse was terminated.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on record review and interview, the facility failed to complete an accurate investigation regarding allegations of abuse for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for abuse. If the facility is not completing an accurate and thorough investigation of allegations of abuse, then the State Agency is unable to appropriately review the allegation for further investigation. The findings are:</p> <p>A. Record review of R #1's face sheet revealed an initial admitted [DATE].</p> <p>B. Record review of the facility's Facility Reported Incident, dated 12/14/24, revealed R #1 called police to report abuse when a nurse tried to stop R #1 from exiting the facility, as he went out to the front parking lot on 12/14/24 at midnight. Resident was assessed and did not have any injuries. The nurse, who tried to prevent R #1 from exiting the building, was placed on administrative leave pending an investigation.</p> <p>C. Record review of the facility's Five Day Follow-Up Report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations), received by the State Agency on 12/19/24, revealed R #1 was out of the facility almost every day for most of the day. Staff reported to the Administration the resident frequently went out front of the building, a car came by the facility, and dropped something off for the resident. The resident went out to the emergency room more than once for a suspected overdose. The facility requested a drug screen during one of the times the resident was at the hospital for suspected overdose; however, the resident refused and left the hospital against medical advice (AMA). R #1 was a known drug connection to the facility.</p> <p>D. Record review of R #1's electronic medical record revealed staff did not document any incidents regarding R #1's suspected overdose, the administration of Narcan (medication used to reverse the effects of narcotic overdose), or being sent to the emergency room for drug overdose during his stay at this facility.</p> <p>E. On 04/24/25 at 1:09 pm during an interview, the Administrator stated he wrote the Five Day Follow-Up Report. The Administrator was not able to verify the resident went out to the emergency room for suspected overdose. The Administrator stated he must have confused R #1 with another resident when he wrote the Five Day Follow-Up Report submitted on 12/19/24. He stated the Five Day Follow-Up Report should be accurate.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was accurate for 1(R #1) of 3 (R #1, R #2 and R #3) residents reviewed for accuracy of assessments. If the MDS assessment is not accurate, then residents are likely to not receive the services they need. The findings are:</p> <p>A. Record review of R #1's Face Sheet dated 03/26/24 revealed this as an initial admitted and included a diagnosis of Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>B. Record review of R #1's annual Minimum Data Set, dated dated dated [DATE], revealed the following:</p> <ul style="list-style-type: none"> - R #1 did not have any behavioral concerns. - R #1 did not have any physical, verbal or sexually inappropriate behavioral symptoms directed toward others. - R #1 did not have any suicidal (thoughts or ideas about harming oneself or killing oneself) or homicidal ideations (thoughts about harming or killing another person). - R #1 did not reject care. <p>C. Record review of R #1's Care Plan, dated 04/07/25, revealed the following:</p> <ul style="list-style-type: none"> - R #1 had behaviors to include drug seeking and behaviors which put him at risk for harm if he did not get what he wanted. R #1 was hypersexual (an intense focus on sexual fantasies, urges or behaviors that cannot be controlled) and made inappropriate comments to female staff. - R #1 was at risk related to verbally abusive and verbalizing homicidal (thoughts of killing others) and suicidal (thoughts of killing self) ideation. <p>D. Record review of R #1's nurse progress notes revealed the following:</p> <ul style="list-style-type: none"> - Dated 01/17/25, R #1 verbalized feeling depressed and stated he felt like he was a danger to himself. - Dated 02/02/25, R #1 verbalized suicidal and homicidal thoughts and stated, Don't be surprised if you come in my room next time and I'm hanging. I feel homicidal, like I am going to kill someone. - Dated 03/27/25, the resident's chief complaint included significant anxiety and depression. R #1 reported ongoing depressive symptoms, occasional thoughts of self-harm, and feelings of isolation (state of being alone or separated from others). R #1's responses were brief, and he showed little interest in discussing symptoms or treatment in detail. <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. Record review of R #1's Change in Condition form, dated 01/17/25, revealed the resident had behavioral symptoms, such as increased bed changes due to soiled linen, difficulty with straight catheter usage, feeling depressed and tired, and generalized pain. Continue to observe resident and remove harmful objects.</p> <p>F. On 4/23/25 at 1:18 pm during an interview with R #1, he stated he thought about suicide and ending his life. R #1 stated he did not want to wake up another day in the facility. The resident stated he was offered psychiatric services, but he refused them.</p> <p>G. On 04/24/25 at 1:54 pm during an interview, the Director of Nursing (DON) stated R #1 had a lot of issues with the facility. The DON stated the resident displayed negative behaviors, like listening to rude, nasty, and derogatory rap music very loudly and being sexually inappropriate with female staff.</p> <p>H. On 04/24/25 at 1:09 pm during an interview, the Administrator stated they had ongoing issues with R #1's aggressive verbal and physical behaviors. The Administrator stated he believed R #1 was drug seeking.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40671</p> <p>Based on observation and interview, the facility failed to protect a treatment cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) from unauthorized access when staff failed to lock the treatment cart while staff were away from the cart. This deficient practice had the potential to affect all 48 residents on the 600 Unit, as identified by the Resident Census provided by the Administrator. If staff fail to lock an unsupervised treatment cart, then residents could obtain medical equipment, which could result in injury or death. The findings are:</p> <p>A. On 04/24/25 at 11:43 AM, during an observation of the 600 Unit, the wound care treatment cart was unlocked and opened. Further observations revealed the cart had wound care items, such as mineral oil, tweezers, and scissors. Staff were not present in the area near the treatment cart.</p> <p>B. On 04/24/25 AM at 11:46 AM, during an interview, Registered Nurse (RN) #1 stated wound care staff and all nurses on duty were responsible for the treatment cart, and staff should lock the treatment cart when they leave it unattended.</p> <p>C. On 04/25/25 at 9:38 AM, during observation of the 600 Unit, the wound care treatment cart was unlocked. Further observations revealed the cart had wound care items, mineral oil, tweezers, and scissors. Staff were not present in the area near the treatment cart.</p> <p>D. On 04/25/25 at 9:40 AM, during an interview, Certified Medication Technician (CMT) #1 stated the treatment cart was unlocked and opened. He said the nurses were responsible for the treatment cart, and they should lock it when the cart was not in use.</p> <p>E. On 04/25/25 at 2:15 PM, during an interview, Director of Nursing (DON) said staff should never leave the treatment cart unlocked while unattended.</p> <p>52440</p>		