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	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites Rio Vista	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for 3 (R #69, R #74, and R #88) of 3 (R #69, R #74, and R #88) residents reviewed when: Non-clinical facility staff was assisting residents with dysphagia (difficulty or discomfort in swallowing, as a symptom of disease) or impaired physical functioning had completed required training and competency validation to safely provide feeding assistance for R #69.The facility failed to provide pre-operative instructions for R #74. The facility failed to transfer R #88 to the hospital after experiencing a femur fracture for multiple days. If the facility fails to adequately train staff in providing feeding assistance, does not deliver essential pre-operative instructions prior to a medical procedure, or fails to timely identify and appropriately transfer a resident with a fracture to a hospital, then residents may receive substandard care and treatment, placing them at risk for preventable harm.The findings are: R #69: A. Record review of R #69's face sheet revealed R #69 was admitted into the facility on [DATE] with the following diagnoses: Parkinson's disease without dyskinesia, without mention of fluctuations (disorder caused by loss of dopamine-producing cells in the brain. It is characterized by symptoms such as tremor, slowed movement (bradykinesia), muscle stiffness (rigidity), and impaired balance), Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), Gastro-esophageal reflux disease without esophagitis (a condition characterized by typical symptoms of acid reflux due to the retrograde flow of gastric contents into the esophagus, without endoscopic evidence of esophageal mucosal injury), Unspecified protein-calorie malnutrition (a condition where a person is not getting enough protein and calories, causing poor nutrition, however the exact severity or type is not specified). B. Record review of R #69's Care Plan dated 05/19/23 revealed the following: Diet alterations related to easy to chew thin liquids, Feeding assistance with all meals in room. C. Record review of R #69's physician orders dated 03/22/25 revealed all medications were to be administered to R #69 whole in applesauce or pudding to make them easier to swallow. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of the facility Activities Department Feeding Assistance Training conducted on 06/13/25 revealed the following was presented: Set up/dignity of clothing protector and explain what you are doing, Drink first, moistens pathway, wakes up mechanism, Bite Size 1/3 to 1/2 at most, 1 item on the fork with each bite, Present food items to bottom lip and check for response, Place food items in mouth and scrape against top teeth/gums, Alternate solids/liquids. Training related to residents with dysphagia was not included. E. Record review of R # 69's Activities Participation Form dated December 2025, and January 2026 revealed the following: 12/18/25: An Activities Assistant (AA) fed R #69 chocolate, 12/24/25: An AA fed R #69 biscotti (traditional Italian twice-baked cookies, typically dry and crunchy) 01/08/26: An AA fed R #69 an unknown dessert. 01/14/26: An AA fed R #69 ice cream. 01/19/26: An AA fed R #69 a cookie. F. On 02/04/26 at 2:53 pm during an interview with the Activities Director (AD), he stated R #69 receives one-to-one support by the activities staff two to three times per week. The AD also stated the Activities Department staff assist with feeding R #69, along with other supportive tasks. The AD stated his department completed feeding?assistance training last year and reported Activities Department staff assist R #69 with feeding. He stated staff received training conducted by the Speech Pathologist (a health professional who diagnoses and treats communication and swallowing disorders across all ages). G. On 02/04/26 at 1:58 pm during an interview with the Speech Pathologist (SP), she stated R #69 was on an easy?to?chew diet and has oral dysphagia related to chewing. She stated R #69's last swallowing assessment was completed on 5/22/23, and a physician?ordered full evaluation dated 3/22/25 was not completed but should have been. The SP stated all non-clinical facility staff that assist residents with feeding, should be trained in the proper competencies and training. The SP confirmed the activities staff was not trained in feeding assistance for residents with dysphagia and should have been. H. On 02/06/26 at 2:59 pm during the interview with the Director of Nursing (DON), she stated activities staff should receive specialized training before being permitted to assist with feeding (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents with a diagnosis of dysphagia. She stated a competency evaluation and training should be completed for any non-clinical staff who would be assisting residents with feeding. The DON stated if staff feed residents who have dysphagia or other swallowing issues, the residents could choke. R #74: I. Record review of R #74's face sheet revealed R #74 was admitted into the facility on [DATE] with the following diagnoses: Other injury of muscles and tendons of the rotator cuff of left shoulder. Chronic pain. J. Record review of R #74's electronic health record (EHR) revealed the following: A physician order dated 01/30/26 for shoulder surgery appointment on 02/02/26 was present. Documentation was not present for pre-operative (pre-op) instructions. No documentation was present that indicated R #74 was educated on pre-op instructions. K. On 02/04/26 at 11:30 am during an interview with R #74, he stated he had scheduled surgery for his shoulder on 02/02/26, but he was unable to have the surgery because he had eaten prior to the appointment. R #74 also stated he was upset staff had not informed him of any pre-operative instructions and noted he would now have to wait for surgery while continuing to experience pain from his shoulder. L. On 02/06/26 at 2:00 pm during an interview with the DON, she confirmed R #74 was scheduled for shoulder surgery on 02/02/26, which was rescheduled because he had eaten prior to the appointment. The DON stated the facility received pre-operative instructions for nothing by mouth before surgery (NPO), which she expected would have been entered into R #74's EHR. She further stated it was her expectation staff would educate R #74 on pre-operative instructions, and document education was given to R #74. The DON confirmed R #74's pre-operative instructions and documentation indicating staff educated R #74 on those pre-operative instructions was not present in R #74's EHR and should have been. R #88: M. Refer to F0689 for related findings. N. Record review of R #88's nursing progress notes dated 10/08/25 through 10/15/25 revealed the following: Dated 10/08/25 at 6:30 am: R #88 experienced a witnessed fall. Resident encouraged to utilize bedrails to hold on to during care. Staff to be more cautious with repositioning of resident during care. Dated 10/08/25 at 8:11 pm: R #88 complains of pain to lower back, right leg and hip, and left arm. Practitioner notified and new orders for topical pain reliever, Oxycodone (opioid pain medication), labs and x-ray (a technique that creates pictures of the inside of the body) given. Will continue to monitor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dated 10/15/25 at 4:30 am: X-ray follow up was positive for right femur fracture. R #88 sent to the emergency department (7 days after experiencing the fall). O. Record review of R #88's provider progress notes dated 10/19/25 revealed the following: Dated 10/19/25: R #88 is examined at bedside. She has returned after a hospitalization for a right femoral fracture secondary to a fall in the facility. She is status post ORIF (Open Reduction and Internal Fixation; surgical procedure to treat serious bone fractures) on 10/16, she currently has a knee immobilizer (a type of brace designed to keep the knee completely straight and prevent movement) on. P. On 02/03/26 at 2:05 pm during an interview with the DON, she stated R #88 was not sent to the emergency room (ER) immediately following the fall. The DON stated this decision was based on the absence of a reported head injury, though the resident did report immediate back pain. She further stated after the fall, a nurse performed a full assessment and notified the provider. Orders were obtained for X-rays of the lower back and the right distal femur. The DON stated these initial X-rays were reported as negative for acute injury to the back and right knee. The DON stated R #88 was complaining of pain in her back immediately after the fall, and due to persistent knee pain, a second X-ray was requested on 10/13/25 and completed on 10/14/25. Results for this x-ray were received on 10/15/25 and revealed a right femur fracture, and R #88 was transferred to the hospital on [DATE]. She stated R #88 wasn't sent out sooner due to her being inconsistent with reporting where her pain was as well as being unable to describe the pain. The DON confirmed residents who experience significant injuries, like a femur fracture, should be sent to the hospital immediately. Q. On 02/10/26 at 2:26 pm during an interview, the Nurse Practitioner (NP), she stated she recalled the fall involving R #88 that occurred in October 2025, which resulted in a femur fracture. The NP clarified that she was not a witness to the event and her knowledge was based solely on facility reports. She stated R #88 reported pain, however, the resident's reporting was inconsistent. The NP stated R #88 was not sent to the ER immediately, but after the second x-ray revealed R #88 had a femur fracture, she was sent to the ER. The NP confirmed residents who experience significant injuries, like a femur fracture, should be sent to the hospital immediately.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure a safe environment and provide adequate supervision to prevent accidents for 1 (R #88) of 1 (R #88) residents reviewed when staff left R #88's bed in the highest position, and R #88 fell from the bed. This deficient practice likely resulted in R #88 sustaining a right femur fracture (long bone that connects the hip to the knee) and spinal compression fractures (a break in a bone in your spine) which required hospitalization. Failure to ensure residents' beds are maintained in the appropriate position while occupied increases the likelihood of avoidable accidents, and places residents at risk for serious injury, significant harm, and potential death.The findings are: A. Record review of R #88's face sheet revealed an admission date of 01/23/23. B. Record review of R #88's care plan revealed the following: Dated 12/20/24: Focus: Impaired physical functioning. Interventions: Bed mobility, and two person substantial/max assist for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). Dated 07/10/24: Focus: R #88 is at risk for falls related to left above knee amputation (AKA). Interventions: Certified Nursing Aides (CNAs) to use Hoyer (mechanical lift used to transfer patients) lift with two persons assist to transfer. C. Record review of R #88's nursing progress notes revealed the following: Dated 10/08/25 at 6:30 am: R #88 experience a witnessed fall; encouraged use of bedrails; staff reminded to use caution during repositioning. Dated 10/08/25 at 8:11 pm: R #88 reports pain to lower back, right leg/hip, and left arm. Practitioner notified; orders for topical analgesic, Oxycodone (opioid pain medication), labs, and X?ray (medical imaging test that uses a small amount of ionizing radiation to create pictures of the inside of the body, particularly bones and certain tissues). Dated 10/10/25 at 10:26 am: Physical Therapy note – R #88 is seen after a fall a few days ago; resident reports 10 out of 10 (worst pain possible) back pain and 5 out of 10 (moderately strong pain) aching pain to the right side of her head. Pain descriptions inconsistent. Higher level of care required due to decline in mobility and increased fall risk. Dated 10/11/25 at 6:17 pm: R #88 complains of lower back and right knee pain; pain worsens with position changes. Dated 10/12/25 at 12:07 pm: R #88 moaning in pain during care; increased right knee pain; right foot edema and bruising noted. CNAs instructed to minimize leg movement. Dated 10/12/25 at 1:23 pm: Provider requested diagnostic imaging; resident reports knee pain at 10 out of 10 despite medication. Dated 10/12/25 at 1:42 pm: Continued 10 out of 10 right knee pain; decline noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Dated 10/13/25 at 6:00 pm: X?ray of right knee ordered; large bruise noted on left hand. Dated 10/14/25 at 6:01 pm: X?ray scheduled for completion. Dated 10/14/25 at 10:15 pm: X-ray to right knee completed. Dated 10/15/25 at 4:30 am: X-ray was positive for right femur fracture. R #88 was sent to the emergency room (ER). Dated 10/15/25 at 1:48 pm: Physical Therapy note – R #88 presents lying in bed, tearful, irritable, and wincing in pain. She reports having pain all over and states she is unable to rate or describe the pain further. Later in conversation, she reports having right leg pain, tenderness with palpation from right hip to toes on the right side. Nursing staff has reported patient yelling when rolled in bed. Dated 10/19/25 at 12:48 pm: Returned from hospital with closed distal femur fracture; computed tomography (CT scan; a noninvasive diagnostic imaging procedure that uses a computer to take data from several X-ray images of structures inside a human and converts them into pictures on a monitor) showed lumbar compression fractures; bruising to upper extremities. D. Record review of R #88's provider progress notes revealed the following: Dated 10/08/25: The chief complaint was for the follow-up of a fall. She denies hitting her head or having a change in level of consciousness. Dated 10/09/25: The chief complaint was lower back and knee pain. Yesterday patient had endorsed pain level 10 out of 10 to lower back however during interview R #88 said she did not report pain. Later in the day she was again reporting lower back and right knee pain. She was inconsistent in her description of pain. She was unable to describe pain; however, she was noted to be screaming loudly. Attempted muscle relaxer as pain would appear seemingly during rest and no movement. This did not relieve symptoms. Discussed starting low dose Oxycodone (opioid pain medication). Patient reports she believed the Oxycodone helped but is not sure. Dated 10/13/25: R #88 is seen today for follow up regarding pain after a fall. Lumbar x-ray reviewed with patient. She continues to endorse nonspecific pain. Patient has been followed closely after recent fall last week. She has appeared very depressed, hopeless, and indifferent. Dated 10/19/25: R #88 is examined at bedside. She has returned after a hospitalization for a right femoral fracture secondary to a fall in the facility. She is status post ORIF (Open Reduction and Internal Fixation; surgical procedure to treat serious bone fractures) on 10/16/25, and she currently has a knee immobilizer (a type of brace designed to keep the knee completely straight and prevent movement) on. E. Record review of R #88's hospital records revealed the following: Dated 10/15/25: Surgical treatment was discussed with R #88 regarding the femur fracture. Surgical interventions would allow R #88 to return to weight bearing and range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point) as tolerated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Dated 10/16/25: Retrograde nail fixation (surgical technique used to repair femur fractures) to R #88's right distal femur fracture was completed. F. On 02/03/26 at 2:05 pm, during an interview, the Director of Nursing (DON) stated R #88 fell during care provided by one CNA, when R #88's bed was in highest position. The CNA asked R #88 to hold onto the handrails during repositioning, and R #88 fell to the floor. The DON stated R #88 was not sent to the ER immediately because R #88 did not report a head injury. She stated the resident did report back pain. The DON stated the nurse assessed R #88 and obtained orders for x?rays of R #88's lower back and right distal femur. The DON stated the x-rays initially read as negative (no fracture). The DON stated a second X?ray was ordered on 10/13/25 due to R #88's persistent knee pain, and the second x-ray was completed on 10/14/25. The DON stated the results from the second x-ray were received on 10/15/25 and showed a right femur fracture. The DON stated R #88 was transferred to the hospital, and the hospital identified a lumbar compression fracture (a collapse or break in one of the vertebrae in the lower spine, often causing back pain and changes in posture). The DON stated R #88's inconsistent pain reporting contributed to a delayed transfer to the ER. The DON stated R #88's bed should not have been in the highest position during care. G. On 02/10/26 at 2:26 pm, during an interview, the Nurse Practitioner (NP) stated she was aware R #88 reported a 10 out of 10 pain following the fall that occurred on 10/08/25. The NP stated initially the staff reported to her that the resident did not have any complaints of pain, so R #88 was not sent out to the ER immediately. The NP stated she recalled one or two X-rays were ordered for the resident. The NP stated the resident was sent to the hospital after the second x-ray identified R #88 had a fractured femur.