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 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 Xˆray (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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. Dated 10/13/25 at 6:00 pm: Xˆray of right knee ordered; large bruise noted on left hand. Dated 10/14/25 at 6:01 pm: Xˆray 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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 xˆrays 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 Xˆray 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure the accuracy of the Minimum Data Set (MDS; a federally mandated comprehensive assessment of a resident's functional, medical, psychosocial and cognitive assessment completed by facility staff) assessments for 2 (R #15 and R #69) of 2 (R #15 and R #69) residents reviewed for MDS assessments, when: R #15's hearing and oxygen (O2) use MDS sections were not accurate,R #69's functional status (resident's ability to complete essential activities to meet one's basic needs and maintain health) MDS section was not accurate and a significant change MDS was not completed. If MDS assessments are not coded accurately, then the resident is at risk of receiving inappropriate or inadequate care due to inaccurate representation of functional abilities and care needs. The findings are: R #15: A. Record review of R #15's face sheet revealed an admission on [DATE] with the following diagnoses: Metabolic Encephalopathy (disruption in brain function without direct physical or structural damage to brain, caused by an underlying condition), Influenza (infection of the respiratory system caused by viruses) due to identified novel influenza A virus with other respiratory manifestations, Acute respiratory failure with hypoxia (condition when blood fails to be oxygenated by the respiratory system), Acute pulmonary edema (a sudden condition when the lungs become fluid filled). Hearing: B. On 02/02/26 at 9:19 AM during an attempted interview with R #15, he continuously responded with the phrase huh when asked questions, indicating he was unable to hear adequately. C. On 02/02/26 at 9:20 AM during an observation of R #15 interacting with another person, R #15 continued to respond with huh when attempting to communicate, indicating he was unable to hear adequately. D. Record review of R #15's MDS dated [DATE], revealed the following: R #15's ability to hear was documented as no difficulty in normal conversation, social interaction, listening to television, no hearing aid in use, and ability to understand others. R #15's hearing aid was documented as R #15 does not using a hearing device. R #15's signs and symptoms of Delirium (inattention, disorganized thinking, altered levels of consciousness) was documented as inattention being continuously present with no fluctuations. R #15's Therapy Services documentation of Speech-Language Pathology (services related to (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication, speech, language, and swallowing disorders) and Audiology Services (services related to hearing, balance, and ear disorders) was documented as administered for at least 15 minutes a day for one or more days in the last seven days. E. Record review of R #15's physician's orders revealed no documentation regarding hearing aids, audiology assessments, or hearing services. F. Record review of R#15's physician's notes dated 01/13/26 to 02/05/26 revealed documented speech is clear; R #15 is able to understand and be understood while speaking. G. On 02/06/26 at 2:22 PM during an interview with Licensed Practical Nurse (LPN) #1, she stated R #15 was hard of hearing, he does not have hearing aids. She stated she believes he has them at home but did not bring them to the facility. H. On 02/12/26 at 4:09 PM during an interview with the Director of Nursing (DON), she stated she was unaware of any issues regarding communication and need or use of hearing aids for R #15. The DON stated it was her expectation regarding difficulty hearing, that the team be made aware and it should be included in the MDS. The DON confirmed if these issues are not in the MDS, it could impact communication and needs of the residents. The DON stated R #15's MDS regarding hearing was not accurate and should be. Oxygen (O2): I. Record review of R #15's physician's orders dated 02/02/26 revealed a room air trial (test conducted by removing O2 from resident to determine O2 saturations in room air) to establish if R #15 was still in need of O2 use. There was not active or discontinued orders related to O2 use for R #15. J. On 02/02/26 at 9:19 AM during an observation of R #15 while outside of his room, R #15 was not observed wearing O2. K. On 02/02/26 at 9:20 AM during an observation of R #15's room, an oxygen concentrator (a medical device that extracts oxygen from ambient air and delivers it at high concentrations to individuals who need supplemental oxygen) was present at R #15's beside without O2 tubing attached, and the machine was not on. L. Record review of R #15's physicians progress notes revealed the following: Dated 01/06/26: Physicians note documented to continue O2 use of one to four liters per minute (LPM) as needed to keep saturations above 90% (percent). Dated 01/07/26: Physicians note documented to continue O2 supplementation and wean as tolerated. Dated 01/09/26: Physicians note documented O2 saturations fluctuating between 77% to 91% on room air, nursing placed on two LPM of O2. O2 saturations recovered to 95%. Dated 01/22/26: Physicians note documented O2 as still low and at two LPM. Dated 01/25/26: Physicians note documented use of O2 via nasal cannula (a small, flexible tube that (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delivers oxygen to the nose through soft prongs). Dated 01/26/26: Physicians note documented use of O2 at two LPM. Dated 01/28/26: Physicians note documented R #15 on room air (no O2 use). Dated 02/02/26: Physicians note documented R #15 on room air. M. Record review of R #15's nursing progress notes dated 01/06/26 through 02/01/26 notes revealed the following: Dated 01/06/26: Nursing note documented no O2 in use. Dated 01/23/26: Nursing note documented no O2 in use. Dated 01/30/26: Nursing note documented R #15 was on room air. Dated 01/31/26: Nursing note documented O2 use via nasal cannula. Dated 02/01/26: Nursing note documented O2 use via nasal cannula. N. Record review of R #15's MDS dated [DATE], revealed there was no documentation regarding the use of O2. O. On 02/12/26 at 4:09 PM during an interview with DON, she stated it is her expectation for O2 use to be documented in the MDS, and if this was not completed it could impact respiratory needs for the residents. The DON confirmed R #15's MDS was not accurate regarding O2 use and should have been. R #69: P. 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), Scoliosis (as a spinal deformity and can occur in the thoracic, lumbar, or both regions of the spine). Q. Record review of R #69's nursing progress notes dated 09/18/25 through 12/24/25 revealed the following: Dated 09/18/25: R #69 is bedbound and is dependent on all activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating), Dated 09/28/25: R #69 is bedbound and is dependent on all ADL's, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dated 11/11/25: R #69 is bed bound, Dated 11/12/25: R #69 is bed bound status, Dated 12/24/25: R #69 is at baseline; she is bed bound. R. Record review of R #69's MDS dated [DATE] through 11/27/25, Section GG (Functional Abilities) revealed the following: Dated 08/27/25: Mobility devices normally used in the last 7 days (Section GG0120) was coded as wheelchair (manual or electric). Dated 11/27/25: Mobility devices normally used in the last 7 days (Section GG0120) was coded as wheelchair (manual or electric). S. On 02/04/26 at 10:37 AM during an observation of R #69, R #69 was observed to be bedbound. T. On 02/03/26 at 2:32 PM during an interview with the DON, she stated R #69's functional decline from wheelchair use to being bed bound should have been considered a change in condition but explained she could not determine when the change had occurred because she had not been present at the time. The DON stated functional decline had been documented in the nursing notes, noting transitioning from wheelchair use to being bed bound was a functional decline and should have been reported from therapy to nursing. The DON stated documentation revealed R #69 had been bed bound since 2023. U. On 02/04/26 at 2:53 PM during an interview with the Activities Director (AD), he stated he had begun his employment at the facility in 2023 and did not recall R #69 using a wheelchair, only remembering her in her bed. V. On 02/16/26 at 2:31 PM during an interview with the DON, she stated R #69's MDS dated [DATE] and 11/27/25 were documented incorrectly because R #69 cannot use a wheelchair and her required level of care is bed bound. The DON stated if MDS are not coded correctly, the residents can receive inadequate care.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) was accurate for 2 (R #3 and R #88) of 2 (R #3 and R #88) residents reviewed for PASARR accuracy.This deficient practice is likely to result in the facility not providing the services needed by residents who are identified in the screening process for additional care and services.The findings are: R #3: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: Anxiety disorder (a psychiatric condition characterized by excessive, persistent fear or anxiety accompanied by behavioral disturbances and physical (autonomic) symptoms, causing significant distress or impairment in functioning), Major depressive disorder, recurrent sever without psychotic features (a serious mood disorder where a person has repeated episodes of severe depression that greatly disrupt daily life, without hallucinations or delusions). B. Record review of R #3's Care Plan dated 11/14/25 revealed the following: Resident will be free of discomfort or adverse reactions related to antidepressant medication use, Monitor, document, report to Medical Director (MD) ongoing signs and symptoms of depression, crying, shame, worthlessness, agitation, irritability, suicide ideations, Resident uses antianxiety medication related to anxiety disorder, Resident uses antidepressant medication related to depression. C. Record review of R #3's PASARR Level I Identification Screening dated 09/16/25, revealed staff documented R #3 did not have a diagnosis of or a suspected mental illness. D. On 02/10/26 at 1:19 PM, during an interview with the Admissions Director (AD), she stated R #3's PASARR Level I Identification Screen did not include R #3's mental health diagnoses. The AD stated R #3 has diagnoses of anxiety disorder and major depressive disorder. She stated if the PASARR screening does not include all pertinent diagnoses, the resident may not be properly screened. R #88: E. Record review of R #88's face sheet revealed an admission date of 01/23/23 with several readmission dates following hospitalizations. R #88's face sheet included the following diagnoses: Generalized Anxiety Disorder (persistent feelings of fear or apprehension). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). F. Record review of R #88's PASARR Level I Identification Screening dated 12/21/24, revealed staff documented R #88 did not have a diagnosis of a suspected mental illness; and neither major depressive disorder nor generalized anxiety were included as diagnoses. G. Record review of R #88's PASARR Level I Identification Screening dated 12/11/25 revealed that neither major depressive disorder nor generalized anxiety were included as diagnoses. H. Record review of R #88's care plan dated 10/21/25 revealed the following: R #88 uses Hydroxyzine (anti-anxiety medication) related to anxiety disorder. R #88 will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. R #88 will show decreased episodes of signs and symptoms of anxiety through next review date. R #88 is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia (memory loss), loss of balance, and cognitive impairment that looks like dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), falls, broken hips and legs. Give anti-anxiety medications as ordered by physician. Monitor and document side effects and effectiveness. I. On 02/11/26 at 3:27 pm during an interview with the AD, she confirmed R #88's PASARR did not reflect R #88's diagnoses of generalized anxiety disorder or major depressive disorder. The AD also stated if there are any missing diagnosis then the PASARR Level I Identification Screening process would be inaccurate. The AD confirmed if the PASARR is inaccurate, then residents may not receive all required services or may be improperly placed in the wrong type of facility and may not have all of their mental health issues addressed and treated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and update a comprehensive, person-centered care plan for 2 (R #8 and R #15) of 2 (R #8 and R #15) residents reviewed for care planning, when staff failed to:Update R #8's care plan to include wound care treatment. Update R #15's care plan to include hearing limitations and oxygen use. These deficient practices are likely to result in residents not having needs met, decreased quality of life, and avoidable decline in physical and psychosocial well-being. The findings are: ˆ R #8: A. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE] with the following diagnoses: Localized Edema (swelling in one specific area of the body caused by extra fluid building up in the tissues), Morbid (severe) obesity due to excess calories (refers to a body weight that is significantly above the healthy range as a result of consuming more calories than the body uses. It is associated with increased health risks and can contribute to impaired mobility, delayed wound healing, and higher risk for pressure injuries), Chronic Diastolic Heart Failure (a longˆterm condition where the heart becomes stiff and cannot relax well, which prevents it from filling with enough blood), Mixed Hyperlipidemia (a condition where a person has high levels of both cholesterol and triglycerides in the blood), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Essential hypertension (high blood pressure with no identifiable medical cause). B. Record review of R #8's Comprehensive MDS (MDS; a federally mandated assessment instrument completed by facility staff) dated 08/25/25 revealed R #8 is at risk of developing pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin). C. Record review of R #8's Physician Orders dated 09/13/2025 revealed R #8 had a wound to the sacrum (lower back) with wound care treatment ordered. D. Record review of R #8's Care Plan dated 09/14/25 revealed there was not wound care interventions documented for a wound identified on 09/13/25. E. On 02/06/2026 at 1:38 PM during an interview with R #8, she stated her wound was acquired in the facility sometime in September 2025. F. On 02/11/2026 at 11:17 AM during an interview with the Director of Nursing (DON), she stated R #8's sacrum wound was first identified on 9/11/25. She stated R #8 's Care Plan was not updated at (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the time of the wound's identification, and the first wound care plan entry for R #8 did not appear until 11/13/25. The DON confirmed R #8's sacrum wound should have been care planned sooner than it was. R #15: Hearing: G. Refer to F0641 for related findings. H. Record review of R #15's care plan dated 01/07/26, revealed there was no documentation available regarding problem, goal, or interventions related to auditory assessment or hearing aids. I. On 02/12/26 at 4:09 PM during an interview with the Director of Nursing (DON), she stated she was unaware of any issues regarding communication and need of hearing aids for R #15. The DON stated it was her expectation for R #15's difficulty of hearing to be placed in the care plan and the team be made aware. The DON confirmed if these issues are not in the care plan, then it could impact communication and needs of R #15. Oxygen (O2): J. Refer to F0641 for related findings. K. Record review of R #15's care plan dated 01/07/26, revealed there was no documentation regarding O2 use as an intervention. R #15's care plan revealed documentation of impaired gas exchange related to respiratory failure (life-threatening condition where the lungs are unable to properly move oxygen and carbon dioxide into and out of the blood) and pulmonary edema (condition when the lungs become fluid filled), with the following interventions: Adequate fluid intake Keep head of bed elevated to avoid shortness of breath while lying flat Monitor for signs of infection O2 use as an intervention was not included in the care plan. L. On 02/12/26 at 4:09 PM during an interview with DON, she stated it is her expectation for O2 use to be documented in the care plan. The DON confirmed R #15's O2 use was not care planned and should have been.

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

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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 4 (R #4, #14, #65, and #85) of 4 (R #4, #14, #65, and #85) residents reviewed when staff failed to: Complete an Abnormal Involuntary Movement Scale (AIMS; used to assess the severity of involuntary movements, particularly in patients taking antipsychotic medications) for R #4 and R #85. Assist R #14 with meals per physician orders and as directed in R #14's care plan. Use appropriate equipment to administer injectable medication (medications administered to body through means of syringe and needle) for R #65. These deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: AIMS: R #4: A. Record review of R #4's face sheet revealed an admission date of 11/30/24 with a diagnosis of Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly). B. Record review of R #4's quarterly AIMS assessment dated [DATE] revealed the following: R #4's overall score was moderate (Mild to moderate involuntary movements; a provider may recommend monitoring the condition or conducting further evaluations, particularly if you are taking medications linked to tardive dyskinesia (TD is a movement disorder characterized by involuntary, repetitive movements, often resulting from long-term use of antipsychotic medications). The exam portion of the assessment revealed R #4 had uncontrolled arm movements noted, rapid, objectively purposeless, and spontaneous with frequent leg twitches. C. Record review of R #4's AIMS assessment dated [DATE], revealed an overall score of 0 (no, or minimal involuntary movements). The exam portion of the assessment revealed R #4 had uncontrolled bilateral abnormal upper extremity movements. For section B: Extremity Movements, it noted for the upper (arm, wrists, hands and fingers), include movements that are rapid, objectively purposeless, irregular and spontaneous: this was scored as none. D. Record review of R #4's physician orders indicated the following: Dated 12/09/25: Risperdal (used to treat schizophrenia) oral tablet, give 0.5 mg (milligrams) by mouth two times per day. Dated 02/11/25: Cogentin (used to treat abnormal movements) tablet, give 1 mg by mouth two times per day. E. Record review of R #4''s electronic health record (EHR) dated 02/05/26 revealed only two AIMS assessments (07/20/25 and 10/25/25) were completed since R #4's admission into the facility. F. On 02/05/26 at 9:35 am during an interview with the Director of Nursing (DON), she stated the AIMS assessments are completed quarterly. The DON stated R #4 should have more than two AIMS (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments completed, since he had been in the facility since 11/30/24 and was on an antipsychotic medication. She stated she was aware of R #4's abnormal involuntary movements, and those movements should be reflected on the AIMS assessment. R #85: G. Record review of R #85's face sheet revealed an admission date of 10/17/25 with the following diagnoses: Major depressive disorder (is a common and serious mental illness that affects your mood and interest in life), Dementia with severe behavioral disturbance (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life and can cause agitation, aggression, mood issues), Suicidal ideations (thought process of having ideas or ruminations about the possibility of dying by suicide). H. Record review of R #85's physician orders dated 11/05/25 revealed the following: Dated 11/05/25: Aripiprazole (antipsychotic used to treat psychosis) Oral Tablet 2 mg, give 1 tablet by mouth in the morning. Dated 11/05/25: Escitalopram Oxalate (used to treat depression) Oral Tablet 20 mg, give 1 tablet by mouth in the morning. Dated 11/05/25: Mirtazapine (used to treat depression) Oral Tablet 15 mg, give 1 tablet by mouth. I. Record review of R #85's EHR dated 02/05/26 revealed an AIMS assessment has not been completed for R #85 since admitting into the facility on [DATE]. J. On 02/05/26 at 9:36 am during an interview with the DON, she confirmed R #85 has not had an AIMS assessment completed since she was admitted into the facility. The DON stated R #85 should have had an AIMS assessment completed due to her taking a antipsychotic medication. Meal Assistance: R #14: K. Record review of R #14's face sheet revealed R #14 was admitted into the facility on [DATE]. L. Record review of R #14's Care Plan dated 01/04/26 revealed R #14 had impaired physical functioning and required substantial/maximum assistance with eating. M. Record review of R #14's physician orders dated 01/09/26 revealed an order for staff to provide feeding assistance for R #14 with every meal. N. On 02/05/26 at 8:54 am during an observation of R #14's room, R #14 was observed eating her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal alone. Further observation revealed R #14's meal ticket showed R #14 required assistance/supervision for all meals. O. On 02/05/26 at 9:06 am during an interview with the Assistant Director of Nursing (ADON), she confirmed R #14 was care planned to receive assistance for all meals. The ADON acknowledged no staff member was present with R #14 during her morning meal and stated staff should have been present. P. On 02/06/26 at 2:10 pm during an interview with the DON, she stated residents with an order for assistance with all meals were expected to have staff present, and all facility staff were responsible for ensuring orders were followed. The DON confirmed feeding assistance during every meal for R #14 was ordered by a physician and care planned. The DON stated R #14 should have feeding assistance for every meal, and that did not happen. Medical Equipment: R #65: Q. Record review of R #65's physician orders dated 12/09/25 revealed an order for heparin (anticoagulant; blood thinner) 5,000 units per 1 mL (milliliter). R. On 02/05/26 at 9:03 AM during a medication administration observation for R #65, Licensed Practical Nurse (LPN) #1 prepared heparin 5,000 units per 1 mL in an insulin syringe and administered it to R #65 via subcutaneous (under the skin) tissue in R #65's abdomen (stomach). S. On 02/05/26 at 9:51 AM during an interview with LPN #1, she stated insulin syringes should only be used for insulin administration. LPN #1 stated she used the insulin syringes as she was not told to use other supplies and was unaware if there were other supplies to use for R #65's heparin injection, or where to locate them. LPN #1 stated she did give the correct dose of 5,000 units per 1mL as the insulin syringe is equivalent to 1mL and showed packaging of insulin syringe which stated 100 units per 1mL. T. On 02/12/26 at 4:09 PM during an interview with DON, she stated it was her expectation that insulin syringes are only to be used for administration of insulin and should not be used for other medications. The DON also stated there are other supplies for injections which should be used. The DON stated insulin syringes are designed for subcutaneous administration and noted she would have to research further outcomes which could arise if other medications such as heparin are administered with an insulin syringe. She stated their insulin syringes are 100 units per 1mL, so if the resident's dose was for 1mL, they would have received a correct dose. The DON confirmed LPN #1 should not have used an insulin syringe when administering heparin to R #65.

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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. 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, (continued on next page)

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	325127	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 feedingˆassistance 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 easyˆtoˆchew diet and has oral dysphagia related to chewing. She stated R #69's last swallowing assessment was completed on 5/22/23, and a physicianˆordered 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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	325127	A. Building B. Wing	02/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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	325127	A. Building B. Wing	02/11/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the proper storage and security of medications and medical supplies located in the medication carts and medication storage rooms, when: R #14's medications were left unattended on top of the medication cart in the 500-hall. Lancets (small needles designed to puncture skin to obtain blood samples for testing) were removed from original packaging and placed in a large bin without labeling or expiration dates. This deficient practice is likely to result in exposure to infectious agents through the ingestion of expired lancets. Additionally, the failure to properly secure medications may result in unauthorized access or diversion by staff, residents, or visitors, potentially leading to adverse outcomes.The findings are: R #14's Medications: A. On [DATE] at 8:39 am during an observation of the medication cart located in the 500-hall, several packs of R #14's medications were observed to be left on top of the medication cart unattended and without nursing staff present. The medications left on top of the cart were Pravastatin (used to lower cholesterol), Methocarbamol (muscle relaxer), and Buspirone (used for depression). B. On [DATE] at 8:41 am during an interview with the Assistant Director of Nursing (ADON) #1, the ADON confirmed R #14's medications should not have been left on top of the medication cart unattended. C. On [DATE] at 8:42 am during an interview with Certified Medication Assistant (CMA) #3, she stated she should have locked up the medications before she walked away from the medication cart. CMA #3 confirmed R #14's medications should not have been left unattended. Lancets: D. On [DATE] at 2:36 pm during an observation of the 200, 300, and 400 halls' medication storage room, lancets were observed to be removed from the original packaging and being stored loosely in a large bin. E. On [DATE] at 2:37 pm during an interview with the Director of Nursing (DON), she stated when the facility receives a new shipment of lancets, they are removed from packaging and placed into a large bin. The DON confirmed storing the lancets like that is unacceptable and should not be done.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure advanced directives (documents providing an individual's wishes for emergency and lifesaving care) were accurate within the Electronic Health Record (EHR) for 1 (R #69) of 2 (R #60 and #69) residents reviewed for advance directives, when: The facility failed to ensure that the advance directive forms and face sheets contained matching and consistent information regarding the residents' end-of-life wishes. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #69's face sheet revealed was admitted into the facility on [DATE] with R #69's code status (information that lets the resident's medical team know what they want and do not want in the event of a medical emergency such as their heart stopping) being a Full Code (lifesaving procedures desired). B. Record review of R #69's New Mexico Medical Orders for Scope of Treatment (NM MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form dated 05/05/23, revealed R #69 was a Do Not Resuscitate (DNR; lifesaving measures are not desired) status (lifesaving measures are not desired). C. Record review of R #69's Care Plan dated 11/03/25, revealed R #69 was a Full Code. D. On 02/06/26 at 2:57 pm during an interview with the Director of Nursing (DON), she stated R #69's NM MOST form identified the resident as DNR, while R #69's face sheet and care plan documented R #69 as a Full Code. The DON confirmed R #69's correct code status was Full Code and stated her expectation is a resident's code status be accurate and consistent across all documentation. The DON stated R #69's NM MOST form was inaccurate and should not have been.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a significant change in condition (major decline or improvement in the patient's health status) Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for 1 (R #88) of 2 (R #60 and R #88) residents reviewed for falls with major injuries. This deficient practice likely resulted in an inaccurate assessment of a resident's injuries and a delay in treatment of a higher level of care. The findings are:^A. Record review of R #88's face sheet revealed an admission date of 01/23/23, a readmission date of 12/11/25, and included the following diagnoses: Collapsed vertebra, lumbar region (when one of the bones in the spine loses height due to pressure, weakness, or trauma in the lower back).Disorders of bone density and structure, multiple sites (conditions where bones become weaker, thinner and abnormally shaped affecting more than one area).Displaced condyle fracture of lower end of femur (break in thigh bone that directly affects the knee joint).Wedge compression fracture of T11-T12 vertebra (one or both of the vertebrae in the lower part of the middle of the back have partially collapsed in the front).Wedge compression fracture of first lumbar vertebra (the front part of the first bone in the lower back has been squeezed or crushed down).Wedge compression fracture of fifth lumbar vertebra (the front part of the lowest bone in the lower back has been squeezed or crushed down). B. Record review of R #88's nursing progress notes revealed the following: Dated 10/08/25 at 6:30 am: Witnessed fall.Dated 10/08/25 at 8:11 pm: Resident 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.Dated 10/10/25 at 10:26 am: Physical Therapy note - Primary care nurse practitioner asked to have resident seen after a fall a few days ago when patient started complaining of 10/10 (pain scale: 0-no pain, 1-very mild pain, 2-minor pain, 3-noticeable pain, 4-moderate pain, 5-moderately strong pain, 6-moderately severe pain, 7-severe pain, 8-very strong pain, 9-excruciating (extremely difficult to bear) pain, 10-worst possible pain) back pain. Resident reports she continues to have 5/10 aching pain to the right side of her head. Higher level of care required secondary to the above diagnosis causing decline in function, mobility, and independence, contributing to an increase in risk of falls, pressure injuries, and poor outcomes. Dated 10/15/25 at 4:30 am - X-ray follow up was positive for right femur fracture. Resident sent to the emergency department.Dated 10/19/25 at 12:48 pm - Resident returned to the facility from the hospital at 12:30 via transport in her wheelchair. Resident had a closed fracture of distal femur, and a computed tomography scan (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) of her spine also showed compression fractures. Resident has bruising to her upper extremities. C. Record review of R #88's provider progress notes revealed the following: Dated 10/19/25 - Resident 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. D. Record review of R #88's MDS assessment reports dated 08/03/25 and 12/01/25 revealed, (despite the major decline in functional status, the surgical intervention, and the diagnosis of multiple fractures) the facility failed to complete a Significant Change MDS until 12/01/25 (approximately one and half months after the injury). E. On 02/03/26 at 2:05 pm during an interview with the Director of Nursing (DON), she stated R #88 was transferred to the hospital on [DATE], and upon evaluation at the emergency room (ER), a compression fracture of the lumbar spine was also discovered. The DON confirmed a Change in Condition MDS for R #88 was not completed following the discovery of these major injuries. The DON stated it was her professional expectation that a Change in Condition MDS for R #88 should have been completed and submitted within 14 days, as the injuries sustained by R #88 were significant.

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	325127	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge Minimum Data Set (MDS; a comprehensive review of the resident's health and functional status) assessments were submitted for finalization within 14 days for 1 (R #7) of 2 (R #'s 7 and 87) residents reviewed for Minimum Data Set. If MDS assessments are not completed and submitted in a timely manner, then the resident is likely to receive less than optimal care.The findings are: A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] and was discharged to the hospital on [DATE]. B. Record review of R #7's electronic health record (EHR) revealed R #7's discharge MDS was not submitted and accepted until 02/10/26 (123 days after R #7's discharge from the facility). C. On 02/12/26 at 11:46 am during an interview with MDS Coordinator (MDSC), she stated R #7's discharge MDS was late and was not completed until 2026. The MDSC confirmed R #7's discharge MDS should have been submitted within 14 days of R #7's discharge, but it was not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure staff revised the care plan for 1 (R #60) of 1 (R #60) residents reviewed when staff failed update R #60's plan of care to include an accurate advanced directive code status.ˆ This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated.ˆ The findings are: A. Record review of R #60's face sheet revealed an admission date of 12/12/25, with R #60's code status (information that lets the resident's medical team know what they want and do not want in the event of a medical emergency such as their heart stopping) being Do Not Resuscitate (DNR; lifesaving measures are not desired) status (lifesaving measures are not desired). B. Record review of R #60's New Mexico Medical Orders for Scope of Treatment (NM MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form dated 01/28/26, revealed R #60 was a DNR. C. Record review of R #60's Care Plan dated 01/26/26, revealed a code status of Full Code (wishes to receive all possible life-saving interventions). D. On 02/06/26 at 2:10 pm during an interview with the Director of Nursing (DON), she confirmed R #60's advanced directive care plan was inaccurate and should have been updated to match R #60's MOST form dated 01/28/26.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received the necessary treatment and services to promote healing of a surgical wound (a cut or incision in the skin that is usually made by a scalpel during surgery) for 1 (R #66) of 1 (R #66) resident reviewed when the facility failed to: Ensure hospital discharge orders for a wound VAC (vacuum-assisted closure; a medical device that uses negative pressure to promote wound healing) were implemented as prescribed. Prevent unauthorized modification of a wound VAC order without provider approval. These deficient practices resulted in R #66's wound care therapy not being delivered as intended, leading to ineffective wound care management. The findings are: Past Non-Compliance Compliance Date: 01/29/26 A. Record review of R #66's face sheet revealed R #66 was admitted into the facility on [DATE] with the diagnosis of an infection following a procedure, deep incisional surgical site. B. Record review of R #66's Care Plan dated 01/23/26 revealed R #66 had skin integrity related to a surgical wound and directed staff to provide wound care as ordered. C. Record review of R #66's Electronic Health Record (EHR), revealed hospital discharge orders dated 01/20/26 to keep the wound VAC on the incision continuously for 6 days at 125 millimeters of mercury (mmHg; a unit of pressure; a setting for the machine.) D. Record review of R #66's Physician Orders revealed an order dated 01/22/26 to remove the wound VAC dressing and foam, cleanse the wound with wound cleanser, and pat dry. The order further directed staff to attach the hose to the wound VAC device, initiate therapy at 125 mmHg continuous suction, and ensure proper function. Staff were instructed to check for leaks each day shift and to provide wound care every Monday, Wednesday, and Friday to the wound. The order also directed staff to assess the wound for any changes and report concerns to the Assistant Director of Nursing (ADON) #2. This order was changed from the hospital discharge orders. E. Record review of R #66's Treatment Administration Record (TAR) dated January 2026, revealed R #66's wound care order was followed only one time on 01/26/26. F. Record review of R #66's Nursing Notes revealed dated 01/25/26 revealed R #66's wound VAC device was set at 190 mmHg; however, no suction was present at the wound site and drainage was observed under the dressing. R #66 notified her surgeon who provided new treatment orders for the facility to discontinue the wound VAC and initiate Xeroform (a sterile, non-adhering gauze dressing) with ABD (thick gauze dressing) until R #66's follow-up appointment on 01/26/26. The surgeon also ordered Linezolid (antibiotic) to be obtained from an outside pharmacy and directed R #66 receive a dose of vancomycin (antibiotic) the morning prior to discharge for the scheduled appointment. The facility provider was notified of the change in order G. On 02/03/26 at 1:45 pm during an interview with the Director of Nursing (DON), she stated she had gone into R #66's room to check-in and R #66 was on the phone with her surgeon. The DON stated she observed R #66's wound VAC device was set at 190 mmHg though no suction was present at the wound site and drainage was observed under the dressing. The DON further revealed the wound had worsened as the sutures of the wound had dehisced (when a surgical incision reopens). The DON stated R #66 knew her wound did not look right and had called her surgeon to discuss. The DON also stated R #66 did not look like her normal self, and R #66 declined to go to the hospital because she wanted to wait until her appointment with her surgeon that was scheduled for the following day. The DON stated she believed the change in orders caused harm to R #66. The DON stated R #66 arrived at the facility on a Wednesday and had her surgical follow-up appointment on the next Monday, which would have been six days, aligning with the hospital orders for the wound VAC to remain in place for six days, but the ADON #2 changed this order. The DON stated this was when she discovered the ADON #2 acted outside his scope of practice by independently changing wound care orders without provider authorization. The DON also stated the ADON #2 confirmed he had changed the orders without authorization. The DON confirmed ADON #2 was immediately placed on suspension, an investigation was conducted, and the ADON #2 was terminated. H. On 02/10/26 at 1:40 pm during an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the Nurse Practitioner (NP), she stated she was not aware R #66's wound had worsened. The NP stated it was her expectation orders would be entered as they were received from the hospital unless a provider approved changes to an order. The NP stated ADON #2 should not have changed the orders himself for R #66. The NP confirmed the power for the wound vac should not have been altered, adding not even she herself would have made any changes unless she received instructions from R #66's surgeon. Evidence for Past Non-Compliance Provided by the Facility: Record review of facility documentation revealed the following: Dated 01/25/26: DON completed immediate review of R #66 hospital transfer order, staff nurse called on call provider with wound status update and order update. New orders were received to align with the prescribed orders. Dressing order was completed as ordered by DON designee. Dated 01/26/26: DON designee completed facility-wide audit to identify any additional residents at risk with wound VACs and verified accuracy of orders. ADON #2 was immediately terminated for failure to follow order changes outside of scope. Report was made to the Board of Nursing. Interdisciplinary Team (IDT; includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, resident or resident representative, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident) adopted new standard process to review all new admissions with wound VACs to confirm orders, settings, and care plan accuracy. DON to conduct weekly audits of all new admissions with wound VAC orders and all newly prescribed wound VAC orders outside of new admissions to ensure accuracy of orders for 8 Weeks. Dated 02/10/26: During review of facility documentation, there were no new admits with wound VACs. Two (R #55, R#99) of two (R #55, R#99) residents with wound VACs in house, had orders verified with no issues. Scope of Practice, Provider Orders, and Wound Care Compliance In-Service: Dated 01/25/26-01/26/26: Employee acknowledgment forms showed a total of seven Licensed Practical Nurses (LPN) and Registered Nurses (RN) were provided education. Education given included appropriate order entry, specifically related to wound VACs, and ensuring all nursing staff practice within their licensed scope. Dated 02/11/26: Four (RN #1, RN #2, LPN #2, LPN #3) of Four (RN #1, RN #2, LPN #2, LPN #3) nurses interviewed confirmed they received education and were able to describe the education they received in detail. All nurses interviewed stated they knew not to make any changes to orders, to consult with a provider, and to defer to the wound care nurse for any residents with a wound VAC. The nurses further stated they felt comfortable reporting if any orders in a resident's chart did not align with orders received from the hospital or other providers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 2 (R #15 and R #69) of 2 (R #15 and R #69) residents reviewed for respiratory care when the facility failed to: Administer oxygen (O2) therapy per physician orders for R #15.Provide the necessary respiratory equipment to ensure O2 was readily available for R #69.These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their conditions.The findings are: R #15: A. Record review of R #15's physician's orders dated 02/02/26 revealed a room air trial (test conducted by removing O2 from resident to determine O2 saturations in room air) to establish if R #15 was still in need of O2 use. There were not active or discontinued orders related to O2 use for R #15. B. On 02/02/26 at 9:19 AM during an observation of R #15 while outside of his room, R #15 was not observed wearing O2. C. On 02/02/26 at 9:20 AM during an observation of R #15's room, an oxygen concentrator (a medical device that extracts oxygen from ambient air and delivers it at high concentrations to individuals who need supplemental oxygen) was present at R #15's beside without O2 tubing attached, and the machine was not on. D. Record review of R #15's physicians progress notes revealed the following: Dated 01/06/26: Physicians note documented to continue O2 use of one to four liters per minute (LPM) as needed to keep saturations above 90% (percent). Dated 01/07/26: Physicians note documented to continue O2 supplementation and wean as tolerated. Dated 01/09/26: Physicians note documented O2 saturations fluctuating between 77% to 91% on room air, nursing placed on two LPM of O2. O2 saturations recovered to 95%. Dated 01/22/26: Physicians note documented O2 as still low and at two LPM. Dated 01/25/26: Physicians note documented use of O2 via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). Dated 01/26/26: Physicians note documented use of O2 at two LPM. Dated 01/28/26: Physicians note documented R #15 on room air (no O2 use). Dated 02/02/26: Physicians note documented R #15 on room air. E. Record review of R #15's nursing progress notes revealed the following: Dated 01/06/26: Nursing note documented no O2 in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 01/23/26: Nursing note documented no O2 in use. Dated 01/30/26: Nursing note documented R #15 was on room air. Dated 01/31/26: Nursing note documented O2 use via nasal cannula. Dated 02/01/26: Nursing note documented O2 use via nasal cannula. F. Record review of R #15's care plan dated 01/07/26, revealed there was no documentation regarding O2 use as an intervention. R #15's care plan revealed documentation of impaired gas exchange related to respiratory failure (life-threatening condition where the lungs are unable to properly move oxygen and carbon dioxide into and out of the blood) and pulmonary edema (condition when the lungs become fluid filled), with the following interventions: Adequate fluid intake Keep head of bed elevated to avoid shortness of breath while lying flat Monitor for signs of infection O2 use as an intervention was not included in the care plan. G. Record review of R #15's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 01/13/26 revealed there was no documentation regarding the use of O2 for R #15. H. On 02/12/26 at 4:09 pm during an interview with Director of Nursing (DON), she stated it is her expectation for O2 use to be ordered through a provider's order in the electronic health record (EHR). The DON stated it was also her expectation for O2 to be documented in the care plan and in the MDS, and if this was not completed it could impact respiratory needs for the residents. R #69: I. Record review of R #69's face sheet revealed the resident 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), Weakness (a reduction in muscle strength or the ability to generate force. J. Record review of R #69's Physician Orders dated 01/21/25, revealed O2 at 1 to 4 LPM per nasal cannula as needed. K. On 02/04/26 at 2:55 pm, during an observation of R #69's room, O2 equipment was not present in R #69's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L. On 02/05/26 at 10:32 am during an observation of R #69's room, O2 equipment was not present in R #69's room. M. On 02/10/26 at 2:02 pm during an interview with the DON, she stated R #69's physician order indicates O2 use at 1 to 4 LPM as needed. The DON stated it is her expectation the appropriate O2 equipment should be present and available in the resident's room.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure a resident had access to dental services and was seen for routine and emergency dental care for 1 (R #69) of 1 (R #69) residents reviewed for routine dental services.This deficient practice could likely result in residents experiencing tooth decay, tooth pain, and difficulty chewing. The findings are: A. Record review of the facility's Dental Services Policy dated 2018 revealed the following: Routine and emergency dental services are available to meet the resident's oral health services in accordance with resident's assessment and plan of care, Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly. B. Record review of R #69's Face Sheet revealed the resident 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). C. Record review of R #69's Physician Orders dated 05/19/23 revealed orders for dental evaluation and treatment as indicated. D. Record review of R #69's Care Plan dated 11/27/24 revealed the resident was dependent on assistance with oral hygiene. E. Record review of R #69's Progress Notes dated 12/29/25 revealed the following:Broken or loose fitting full or partial denture (chipped, cracked, uncleanable, or loose): Not Assessed.Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn): Not Assessed,No natural teeth or tooth fragment(s) (edentulous) Not Assessed,Obvious or likely cavity or broken natural teeth: Not Assessed,Inflamed or bleeding gums or loose natural teeth: Not Assessed,Mouth or facial pain, discomfort or difficulty with chewing: Not Assessed. F. Record review of R #69's Quarterly MDS (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/27/25 revealed R #69's oral hygiene was documented as resident needing supervision or touching assistance. G. Record review of R #69's Comprehensive MDS dated [DATE] revealed R #69's oral hygiene was documented as resident needing supervision or touching assistance. H. Record review of R # 69's Quarterly MDS dated [DATE] revealed R #69's oral hygiene was documented as resident needing supervision or touching assistance. I. Record review of R #69's electronic health record (EHR) dated 02/04/26 revealed there was no documentation present that indicated R #69 has had a dental evaluation or treatment completed. J. On 02/04/26 at 9:35 am during an observation of R #69, she was observed to have broken teeth with visible plaque buildup and discoloration. K. On 02/04/26 at 11:54 am during an interview with R #69, she stated she has not seen a dentist since before admission and she was experiencing dental pain that staff were aware of. L. On 02/10/26 at 2:50 pm during an interview with the Director of Nursing (DON), she stated R #69 had not received dental services since admission into the facility due to the facility's inability to secure mobile dental services. The DON stated R #69 is bedbound and unable to transfer into a wheelchair for outside dental appointments. The DON also stated it is her expectation for residents to receive routine dental services in a timely manner regardless of their level of care. The DON stated residents who do not receive routine dental care, may be at risk for complications related to poor oral hygiene. The DON confirmed R #69 should have had a dental evaluation and/or treatment provided, but that did not happen.