STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the guardian of a change in condition for 1 (R #3) of 2 (R #3 and R #9) residents reviewed for weight loss. This deficient practice is likely to cause residents to go without needed interventions, if the guardian of the resident is unaware of the change in condition. The findings are: A. Record review of R #3's face sheet revealed she was admitted into the facility on [DATE] with the following diagnoses: -Osteoarthritis (chronic degeneration of the joint cartilage), -Bi-polar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), -Type II diabetes (a disease in which the body cannot make or properly use insulin), - Atherosclerosis of native arteries (hardening of your arteries from plaque building up gradually inside them, plaque buildup limits blood flow causing complications like a heart attack or stroke), - Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). B. Record review of R #3's face sheet revealed the guardian for R #3 was listed as emergency contact #1, guardian, responsible party and responsible for statement (financial). There is an address listed along with a cell phone number and an office number. C. Record review of R #3's physician's orders revealed the following: -On 09/17/25 R #3 was on regular diet, soft and bite sized texture, thin consistency. -On 09/18/25 R #3 needs assistance with meals for expected decline due to disease process. -On 10/03/25 R #3's diet changed to a regular diet, puree texture and thin consistency. D. On 11/26/25 at 9:10 am, during an interview with the Director of Nursing (DON), she stated R #3's guardian was upset about a few things. He was upset about not being notified of the diet change and R #3's decline due to disease process. The DON stated the guardian had not been around at all and none of the nurses knew him. She stated when she spoke to the nurse about not notifying the Guardian, the nurse stated she did not know who the Guardian was and notified the grandson instead. E. On 11/26/25 at 9:21 am, during an interview with Social Services Director (SSD), she stated R #3's guardian had a few issues with the notification process. She stated she called to speak with him (she could not recall the date) and the guardian told her that he was unaware R #3 had a decline and diet change, and he was not notified of these changes. The SSD stated she was unclear on whether or not he was notified of the diet change and the decline. F. On 11/26/25 at 10:00 am during an interview with R #3's guardian, he stated he was not notified of R #3's change in condition and her diet change. The guardian stated he was not notified of her overall condition and he should have been notified of all of these changes. G. Record review of R #3's electronic medical record (EMR) revealed the medical record did not contain any documentation of the guardian being notified of R #3's change in condition or diet change after R #3 returned from the hospital on [DATE].

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on video observation, record review, and interview, the facility failed to prevent an employee to resident abuse for 1 (R #9) of 3 (R #9, #10 and #11) residents reviewed for abuse. This deficient practice likely resulted in psychosocial harm based upon the reasonable person concept to the resident related to fear of physical harm and mistrust of the caretaker she was dependent on for all of her care. The findings are: Past Non-ComplianceCompliance Date: 11/18/25 A. Record review of R #9's face sheet revealed she was admitted on [DATE] and had the following diagnoses: Cerebral infraction due to embolism (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) or (stroke),Type II diabetes mellitus (DM2 is a disease in which the body cannot make or properly use insulin),Vascular Dementia (a blockage of the blood supply to the brain. It is manifested with decline of memory and cognitive functions),Parkinson's (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination),Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease).R #9 was on hospice, start date 10/15/25. B. Record review of R #9's care plan initiated on 05/29/25 and 05/30/25 revealed that R #9 had the following: initiated on 05/29/25 that R #9 is dependent on staff for all activities of daily living,initiated on 05/30/25 to use Hoyer lift (equipment used to move residents who have limited mobility) every shift related to hemiplegia (paralysis on one side of the body) affecting left non-dominant side, two persons assist when using. C. Record review of R #9's electronic medical record (EMR), vitals tab, indicated R #9 weighed 105 pounds on 11/02/25. D. Record review of the Brief Interview of Mental Status (BIMS; a screening for cognitive impairment, scores range from 00 to 15, with 15 - 13 is cognitively intact, 12 - 8 is moderately impaired, 7 - 00 is severe impairment) assessment for R #9, indicated resident was unable to complete the BIMS assessment due to R #9's cognitive impairment. E. Observation of video taken on 11/09/25 at 6:58 pm of R #9's room revealed the following: R #9 in bed lying on her back. Hoyer lift on the left side of the bed and Hoyer lift sling under the resident. Staff member, Certified Nursing Assistant (CNA) #9 was on the right side of the bed facing the resident and was changing R #9's brief. The video showed CNA #9 forcefully and aggressively grabbed R #9 on her right leg and right hand. CNA #9 pulled her onto her side, almost rolling her off the bed. R #9's brief had also been unattached and was not secured on the sides. CNA #9 then forcefully and aggressively pushed R #9 onto her back. CNA #9 pulled up the brief and threw R #9's gown up above her stomach and moved the Hoyer sling to the bottom of the bed. CNA #9 appeared very angry and frustrated and although unclear on the video, was saying something to the resident. R #9 appeared scared of CNA #9 and confused by what was happening based upon the expression on her face. CNA #9 was seen pushing and pulling R #9 in her bed and appeared strong, dominant and intimidating over R #9 who appeared frail, and weak. CNA #9 pulled up the brief and secured it. Video ends. F. Record review of R #9's nursing progress notes dated 11/09/25 at 8:26 pm, revealed the on-call nursing manager called the facility to ask about R #9 and who had placed her to bed. The note indicated it was the CNA on duty (CNA #9). CNA was asked to go home as an investigation was starting. Two nurses conducted a nursing assessment (head to toe assessment looking for bruising, scratches) on R #9. No new skin issues were detected, no redness was observed anywhere on the body and no new skin tears, lacerations (a wound produced by tearing) or abrasions (partial thickness wound caused by damage to the skin) found on the body. G. Record review of R #9's incident note dated 11/10/25 at 4:09 am, nurse from the 2nd floor was directed to perform a thorough skin assessment on R #9 with the 3rd floor nurse due to allegations of abuse. Head to toe skin assessment was performed on resident to which no findings of skin damage or impairments were found. Residents skin was clean, dry, and intact from head to toe with no discoloration found. No redness, scratches, bruises, or signs of friction or moisture associated skin damage was seen. H. On 11/17/25 at 8:50 am during an interview with the Administrator (ADM), she stated she received a text message from R #9's daughter stating she was watching the video that is in her mother's room (R #9) and watched a staff member abuse her mother. The Administrator stated she immediately had CNA #9 pulled off the floor and sent home. She had R #9 assessed by two nurses working that night shift. R #9 was assessed to be free of any physical injury. The ADM stated an investigation was started immediately although the R #9's daughter did not have administrator access to pull the video clip and send it to the administrator. The daughter stated her brother had administrator access. The ADM stated she did not see the video until the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to: - Complete necessary assessments, -Open a risk management report, -Create interventions for a fall, and-Use two staff when using the Hoyer lift (equipment used to move residents who have limited mobility). for 2 (R #1 and R #9) of 2 (R #1 and R #9) residents reviewed for falls. Failure to provide fall prevention interventions and facility staff using the Hoyer lift with only one person are likely to cause accidents, injuring the resident. The findings are: Findings for Fall Assessment R #1: A. Record review of the face sheet for R #1 indicated she was admitted on [DATE] and had the following diagnoses: -Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), -Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), -Frontal lobe and executive function deficit from cerebral infarction (responsible for higher cognitive functions including language, memory, problem solving, and judgment), -Hypertension (high blood pressure), -Cardiac pacemaker) small battery operated device that helps regulate the heart's rhythm by sending electrical impulses to stimulate heartbeats). B. Record review of R #1's nursing progress notes dated 09/29/24 revealed the following: -R #1 was found on the floor next to her bed. She was awake and alert, denied pain. No obvious injury. Vital signs were within normal limits (standard or typical). -R #1's son requested R #1 be sent to the hospital. R #1 was sent to the hospital. -R #1 had no injury from the fall, but it was discovered R #1 had a urinary tract infection (UTI) and was treated with antibiotics. C. Record review of R #1's assessment tab in the Electronic Medical Record (EMR) revealed there was no fall assessment completed, no neuro checks (a brief neurological assessment performed by staff repeatedly to monitor a resident's neurological status) completed, no change in condition completed, no post fall assessment and no interventions in place for the fall that occurred on 09/26/24. D. Record review of R #1's care plan initiated on 09/26/24 revealed that there was not a care plan focus or intervention for the fall on 09/26/24. The first care plan item for falls was dated 10/26/24 after the second fall occurred. E. Record review of R #1's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/01/24 revealed R #1 had upper and lower extremity impairment (loss of use) on one side. R #1 required full assistance with eating, dressing, hygiene and was a moderate to partial assist for rolling from back to left side to back again when in bed. F. On 11/17/25 at 10:30 am, during an interview with R #1's son, he stated he was notified of the fall on the morning of 09/26/24. R #1's son also stated when he spoke to the Nurse Practitioner (NP) (not sure of the exact date) about fall mats being placed on the side of the bed, the NP stated they don't use fall mats because they are a restraint to residents. He was told he could buy a sensor for the bed if he wanted to. He stated no interventions were done for the fall on 09/26/24. G. On 11/18/25 at 12:45 pm, during an interview with Licensed Practical Nurse (LPN) #5, she stated when a resident has a fall she would be notified right away, and she would go down and assess the resident. She would check vitals, including neuro checks, pain, bruising, if the resident was bleeding, and if they hit their head. She would send the resident to the hospital if needed or requested from family and physician. Notification of everyone who is notified of a fall. H. On 11/19/25 at 10:13 am, during an interview with Director of Nursing (DON), she stated when a resident has a fall, a nursing assessment for falls is completed whether it was witnessed or not witnessed. The nurse would look for injuries, if the resident hit their head. Neuro checks are done for every fall, and a post fall assessment is completed the next day. They would open a risk management for the fall and then interventions would be discussed once they have determined the cause of the fall. The DON stated fall mats are used in this building and the resident would be assessed if they are appropriate or not. The DON confirmed none of this was completed for the fall on 09/26/24 for R #1. Findings for Hoyer lift R #9: I. Record review of R #9's face sheet revealed she was admitted on [DATE] and had the following diagnoses: Cerebral infraction due to embolism (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) or (stroke), Type II diabetes mellitus (DM2 is a disease in which the body cannot make or properly use insulin), Vascular Dementia (a blockage of the blood supply to the brain. It is manifested with decline of memory and cognitive functions), Parkinson's (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination), Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). J. Record review of R #9's care plan revealed the following: -initiated on 05/29/25, R #9 is dependent on staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to capture an accurate and consistent weight for 1 (R #1) of (R #1) residents reviewed for weight loss. This deficient practice potentially created a delay in R #1 receiving a nutritional supplement due to missing and inaccurate weights, which likely contributed to weight loss. The findings are: A. Record review of R #1's Electronic Medical Record (EMR) revealed she had dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), frontal lobe and executive function deficit from cerebral infarction (is responsible for higher cognitive functions including language, memory, problem solving, and judgment), hypertension (high blood pressure), cardiac pacemaker) small, battery-operated device that helps regulate the heart's rhythm by sending electrical impulses to stimulate heartbeats). R #1 was admitted to the facility on [DATE]. B. Record review of R #1's physician orders indicated the following: weigh on admission then weekly X (times) 4 weeks every day shift every Thursday for routine monitoring for 5 weeks. Start date 09/26/25. C. Record review of R #1's care plan dated 09/26/24 indicated the following: eating assistance level: assist of 1, she can refuse to open her mouth start date 09/25/24. D. Record review of R #1's weight log revealed the following: - 09/25/24 125.0 pounds (Lbs) - 10/08/24 125.0 Lbs - 10/17/24 150.5 Lbs a note next to the weight documented that the weight was documented incorrectly -10/25/24 113.0 Lbs -10/30/24 111.4 Lbs E. Record review of the electronic medical record for R #1 did not reveal a weight for 10/02/25 that was missed and there was no order for a re-weight on the inaccurate weight on 10/17/25. F. Record review of R #1's mini nutrition progress note revealed on 10/08/24 resident weighed 125 lbs. Resident has mild dementia. Resident Body Mass Index is greater than 21 and less than 23. R #1's Mini Nutrition Score is: 6.0 12 - 14 points: Normal nutritional status 8 - 11 points: At risk of malnutrition 0 - 7 points: Malnourished G. Record review of R #1's physician orders indicated the following: give Ensure drink at each mealtime, three times a day for insufficient nutrition. Start date 10/25/24. H. On 11/17/25 at 12:15 pm, during an interview with the Nutritional Services Director (NSD), she stated she works closely with the Registered Dietician (RD). She stated weights have been an issue because the weights don't get done according to the physician order which is usually once per week for five weeks and monthly after that. Getting reweighs done has also been an issue and they are almost impossible to get. She remembers R #1 was not eating and refusing most of her meals. R #1 was ordered a protein shake and was to be in the dining room for meals because she required assistance with eating. She stated that she was very malnourished. She stated most of the meal percentage documentation was not accurate. She stated she would see documentation of R #1 eating 50 to 75% of her meal but her plate would come back totally full. I. On 11/19/25 at 10:09 am, during an interview with Assistant Director of Nursing (ADON), she stated getting weights done has been a problem. When new residents come into the facility on admission they will usually get weighed the first three days and then for four weeks after that. Getting a re-weigh for a weight that is inaccurate can also be a challenge. The staff view weights as a vital sign and need to be completed and accurate. J. On 11/19/25 at 10:13 am, during an interview with the Director of Nursing (DON), she stated that weights have not always been consistent and because they have not always been consistent and getting reweighs has also been challenging. K. On 11/19/25 at 12:25 pm, during an interview with the Registered Dietician (RD), she stated she is in contact with the NSD all the time. The RD stated she is notified of weight loss through call, text or email. The electronic medical record (EMR) also notifies of weight loss and it will be on the EMR dashboard for the resident who has weight loss or abnormal vitals. The RD stated there had been issues with getting weights and re-weighs and stated they had not been done consistently. The RD stated it is impossible to know if they weight loss or gain is a true weight loss or gain if a reweigh isn't done. The RD stated for R #1 if her weight on 10/17/24 was inaccurate, she was not reweighed, and her next weight was 10/25/24 and showed a 9-pound weight loss. The RD confirmed there was a delay in getting R #1 a weight loss supplement and addressing R #1's weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325130	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhood IN Rio Rancho	900 Loma Colorado Blvd NE Rio Rancho, NM 87124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have accurate and complete medical records for 2 (R #1 and R #11) of 3 (R #1 and R #9 and R #11) residents reviewed for showers, falls, and nutrition. This deficient practice could likely cause: - confusion on the resident's status if the history and physical was not accurately documented, -residents to go without fall interventions in place because there was no documentation of the fall, -residents could potentially suffer weight loss without appropriate interventions due to inaccurate meal intake documentation. The findings are: Inaccurate description on History and Physical: A. Record review of R #1's face sheet indicated R #1 was admitted on [DATE] with the following diagnosis: -Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), -Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), -Frontal lobe and executive function deficit from cerebral infarction (frontal lobe are responsible for higher cognitive functions including language, memory, problem solving, and judgment), -Hypertension (high blood pressure), -Cardiac pacemaker (small battery-operated device that helps regulate the heart's rhythm by sending electrical impulses to stimulate heartbeats). B. Record review of R #1's History and Physical dated 10/08/25 in the physical exam section indicated for musculoskeletal (made up of bones, muscles, tendons, ligaments, and connective tissues that provides support, stability, and movement to the body): R #1 is able to move all four extremities independently. C. Record review of R #1's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/01/24 indicated R #1 had upper and lower extremity impairment (loss of function or impairment to your limbs) on one side. R #1 required full assistance with eating, dressing, hygiene and was a moderate to partial assist for rolling from back to left side to back again when in bed. Findings for: No documentation of a fall: D. Record review of R #1's nursing progress notes dated 09/29/24 indicated R #1 was found on the floor next to her bed. No injuries noted. E. Record review R #1's assessment tab in the Electronic Medical Record (EMR) indicated there was no fall assessment completed, no neuro checks completed, no change in condition completed, no post fall assessment and no interventions in place for the fall that occurred on 09/26/24. F. Record review of R #1's care plan initiated on 09/26/24 revealed that there was not a care plan focus and intervention for the fall on 09/26/24. G. On 11/17/25 at 10:30 am, during an interview with R #1's son, he said he was notified of the fall on the morning of 09/26/24 but no interventions for this fall were put into place. H. On 11/19/25 at 10:13 am, during an interview with the Director of Nursing, she stated that no documentation around the fall occurring on 09/26/25 for R #1 is documented in the chart. The DON stated because a fall risk assessment was not completed, so no interventions were put in place for this fall. Findings for: Inaccurate or no documentation on the Activities Daily Living (ADL) Task List (documents daily on whether the task occurred, how many staff it took to perform a task, documents eating and fluid intake. R #1: I. Record review of the ADL list for R #1 from 09/25/24 to 09/30/24 indicated that no documentation was entered for any of the categories on the ADL list. J. Record review of the ADL list for R #1 from 10/01/24 to 10/31/24 indicated that no documentation was entered from 10/01/24 to the morning on 10/07/24 for any of the categories on the ADL list. K. Record review of the ADL list for R #1 indicated there was no documentation on the a.m. shift for R #1 on the following days: 10/10/24, 10/11/24, 10/13/24 10/15/24, 10/16/24, 10/22/24, 10/23/24, 10/26/24, 10/27/24, 10/30/24 and 10/31/24 for any of the categories on the ADL list. L. Record review of the ADL list for R #1 indicated there was no documentation on the p.m. shift for R #1 on the following days: 10/09/24, 10/11/24, 10/23/24, 10/31/24 for any of the categories on the ADL list. Showers for R #11 M. Record review R #11's electronic medical record (EMR) indicated R #11 went on hospice 10/10/25 and hospice is responsible for showers on Monday and Wednesday. N. Record review of R #11's ADL list for showering from 09/01/25 to 09/30/25 revealed documentation on 09/11/25 that R #11 was showered. No other documentation for showers was on the task list. O. Record review of R #11's ADL list for showering from 10/01/25 to 10/10/25 revealed documentation R #11 received a shower on 10/09/25. No other documentation for showers was on the task list. Incorrect documentation of meal percentage R #11 P. Record review of the physician orders for R #11 revealed that an order to assist with all meals for increased intake dated 09/17/25. Q. Record review of the ADL list for meal intake for R #11 dated 11/17/25 indicated that R #11 ate 75 percent to 100 percent of his meal at lunch time. R. On 11/18/25 at 12:35 pm, during an interview with Certified Nursing Assistant (CNA) # 7, she stated she was R