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	03/13/2026

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 - Minimal harm or potential for 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. Based on record review and interview, the facility failed to ensure 1 (R #1) of 4 (R #1, #2, #3, and #4) residents were free from physical and mental abuse, when: The facility failed to ensure a safe environment by not preventing a physical and verbal altercation between two staff members that occurred on the bed in R #1's room, resulting in R #1 witnessing the altercation and becoming fearful. If the facility fails to provide an environment free from abuse, then residents are at risk for physical injury and psychological harm. The findings are: A. Record review of R #1's face sheet revealed an admission date of 01/28/26 and included the following diagnoses: Displaced fracture of greater trochanter of right femur (a serious injury where the bone connecting the hip joint to the thigh bone is broken, causing the two pieces to be misaligned). Unspecified fall. Chronic obstructive pulmonary disease (COPD; lung disease). Type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin).Hypertension (HTN; high blood pressure). Pulmonary embolism with acute cor pulmonale (when an obstruction in a blood vessel in the lungs causes your right sided heart failure).Generalized muscle weakness.Cognitive communication deficit (a condition where impairments in cognitive processes disrupt a person's ability to communicate effectively). B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 02/04/26, revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 10, moderate impairment. C. Record review of the local police report involving R #1, dated 2/17/26, revealed the following:Police responded to the facility at approximately 1:06 am regarding a battery call for service (a situation where someone reports that a person has been unlawfully and intentionally touched or struck in a harmful or offensive way). Certified Nursing Assistant (CNA) #4 stated Registered Nurse (RN) #1 pushed him, and he then pushed RN #1 into a resident room where CNA #4 stated he punched RN #1 in the face one time and then restrained her to the ground to prevent her from pushing him again. RN #1 was observed by police to have multiple major injuries, her clothing was stretched out, and she was missing a shoe.RN #1 reported having ongoing issues with CNA #4 as he had gotten in her face in past incidents; this was the first time it turned physical. RN #1 reported that she heard CNA #4 yelling in a patient's room. She remained in the hallway and observed CNA #4 yelling at the Director of Nursing (DON) over the phone while in a resident's room. At that time, she advised CNA #4 to leave the facility and take the phone call elsewhere. She reported that after this request, CNA #4 approached her and punched her multiple times in the face with a closed fist, causing a broken tooth and a laceration behind her ear. CNA #4 then grabbed RN #1 by the collar of her shirt and dragged her into R #1's room, causing scratches to her upper chest. While in R #1's room, CNA #4 sat on top of RN #1 while she was on the ground and placed his knee against her chin, causing a red mark on her chin and neck and restricting her ability to move. D. On 03/12/26 at 11:20 am, during an interview, R #1's Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) stated she interviewed R #1 after the incident and R #1 did report to her that she was frightened, feeling depressed, and anxious after witnessing an incident with two staff members engaging in a verbal and physical altercation. R #1 reported to the Psychiatrist she was in her bed when she was awoken by noise and feeling her bed (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	move. R #1's Psychiatrist stated CNA #4 was physically striking RN #1, so R #1 took her walker and left to another resident's room. R #1's Psychiatrist confirmed during the interview, she observed R #1 to be anxious, and R #1 stated she did not feel safe in the facility. E. On 03/13/26 at 10:27 am, during an interview, Certified Nursing Aide (CNA) #4 stated a verbal and physical altercation occurred between himself and RN #1 on 02/16/26 at about 12:50 am. He stated the incident began in the hallway when RN #1 asked him where he had been and why he wasn't answering the phone. He stated RN #1 then got in his face, was yelling at him, and spit on him. He stated the physical struggle moved into R #1's room, with RN #1 climbing up on the resident's bed while R #1 was still in bed and repeatedly kicked at him. He stated while they were in R #1's room, prior to RN #1 climbing onto the bed, RN #1 pushed a bedside table with a pitcher of water at him and again spit at him. He stated his main priority was to help R #1 out of the room safely, as R #1 appeared startled and to be negatively affected by the altercation. CNA #4 stated he contacted the DON via telephone and advised her that he was going to be leaving, and he had also contacted the police. He stated when the DON arrived at the facility, he was in handcuffs seated in a police car and was subsequently arrested because RN #1 was bleeding and had a chipped tooth. He stated he told the police he was only blocking RN #1's kicks and did not recall hitting her. F. On 03/13/26 at 11:38 am, during an interview, the DON stated when she arrived at the facility, staff had already moved the furniture in R #1's room back to its' original place. The DON stated R #1 was wrapped in a blanket, seated with two CNAs who were consoling her. The DON stated she calmly spoke with R #1, and they walked around the hall for about twenty minutes so the DON could observe her to ensure there were no physical injuries. R #1 was then assessed for pain and was asked if she had been hit by anyone during the altercation, to which R #1 replied no. The DON stated R #1 was very anxious and told the DON she heard loud voices and then her bed was bumped. G. On 03/13/26 at 11:42 am, during an interview, the Administrator (ADM) stated the DON called her immediately upon arriving to the facility and advised her that CNA #4 was in handcuffs and in police custody. She stated the DON advised she had immediately assessed R #1 while she was sitting with two CNAs.