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	05/23/2024

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49196 Based on interview and record review, the facility failed to ensure the comprehensive care plan was updated for 1 (R #28) of 1 (R #28) residents reviewed for care plan accuracy. This deficient practice could likely result in staff not understanding and implementing the most appropriate interventions and treatments for the resident. The findings are: A. Record review of R #28's Electronic Medical Record (EMR) revealed R #28 was admitted to hospice services on 01/17/24 and received these services. B. Record review of R #28's care plan, reviewed on 04/24/24, revealed the care plan did not contain information about hospice services. C. On 05/22/24 at 2:34 PM during an interview, the facility's Social Services Director (SSD) stated R #28's care plan did not include hospice services, and staff should have updated the resident's care plan to include hospice services.

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35632 Repeat deficiency. Based on record review and interview, the facility failed to meet professional standards of quality when staff failed to notify the Pharmacist and the Director of Nursing (DON) of a morphine spill and a missing fentanyl patch for 2 (R #1 and #13) of 2 (R #1 and #13) residents reviewed for medications. This deficient practice could cause a resident to not receive the pain medication that was prescribed and could also cause confusion when reconciling medications. The findings are: R #1 A. Record review of the physician orders for R #1 indicated an order for a fentanyl patch, 25 micrograms (mcg), every 72 hour; amount: one patch transdermal (absorbed through skin into bloodstream). Special Instructions: Apply transdermal patch onto lower back once every 72 hours. Start date 09/13/23. B. Record review of R #1's nursing progress notes, dated 01/21/24, indicated the writer applied a new fentanyl patch to the resident's right shoulder with protective cover and dated it. The writer and the other Licensed Practical Nurse (LPN) on staff did not find the old patch. C. On 05/23/24 at 10:08 am, during an interview with Nurse (N) #5, she stated she was not aware the nurses did not find and destroy R #1's fentanyl patches. She stated she thought the Assistant Director of Nursing (ADON) was aware of the January 2024 incident, but none of them were aware of it. N #5 stated the management staff could not find any documentation about the January 2024 incident. N #5 stated the nurse managers should be aware of missing fentanyl patches if staff cannot find the patches. D. On 05/23/24 at 12:17 pm, during an interview with the Assistant Director of Nursing (ADON), he stated staff notified him in the past if they could not find a fentanyl patch. He was not aware of a missing patch for R #1 on 01/21/24. E. Record review of the Medication Administration: Topical Patch Procedure, revised 10/2023, indicated if staff determined a patch to be missing, then the nursing staff should investigate and attempt to find the missing patch to dispose of properly. Staff should notify the Director of Nursing Services if they do not locate the patch. R #13 F. Record review of the current physician orders for R #13 indicated an order for morphine concentrate solution, administer 0.5 to 1 ml orally, as needed for shortness of breath or pain. Start date 05/09/23. G. Record review of the narcotic log sheet for R #13, dated 05/20/24, indicated 4 ml of morphine were wasted. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 05/23/24 at approximately 9:30 am, during an interview with the Pharmacist, she stated she expected staff to notify her if there was a waste of morphine medication. She stated staff did not notify her that R #13's morphine was spilled on 05/13/24. She stated she expected a new order for the morphine, and the old bottle to be destroyed after the new one had come in. I. On 05/23/24 at 10:07 am, during an interview with the Director of Nursing (DON), she stated she was not aware staff spilled R #13's morphine. She stated they found documentation of the spill on the Narcotic log sheet, and the morphine bottle was still in the medication cart.

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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** 50752 Based on record review, and interview, the facility failed to provide quality of care when they did not provide wound care for 1 (R #17) of 1 (R #17) residents review for skin conditions. This deficient practice could likely result in the resident not receiving appropriate and timely wound care resulting in discomfort and infection. The findings are: Findings for R #17 A. Record review of R # 17's face sheet revealed the resident was admitted on [DATE] with diagnoses that included but was not limited to: - Malignant melanoma (skin cancer) of skin of breast, - History of unspecified open wound of right front wall of thorax (area of the body situated between the neck and the stomach) without penetration into thoracic cavity, - Surgical removal of right breast and nipple. B. Review of R #17's Medication Administration Record (MAR), revealed the following: 1. Wound Care for wound on right breast: a. Cleanse with cleaning agent. b. Pat Dry. c. Apply antibiotic ointment. d. RN will apply dry dressing, cover with 4 by 4 foam. Measure length, width, and depth of wound of the breast area. e. Notify physician if wound increased in size. Every day shift related to malignant melanoma of skin of breast. f. Start date 05/14/24. 2. Wound Care to front wall of thorax: a. Hospice provided wound care to wound, as needed, every three days. Started 05/14/24. C. Record review of R #17's MAR, dated 05/14/24 through 05/23/24, revealed staff completed wound care treatment two out of 10 times, as follows: - On 05/14/24, staff did not provide treatment, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 05/15/24, staff did not provide treatment, - On 05/16/24, staff provided treatment, - On 05/17/24, staff provided treatment, - On 05/18/24, staff did not provide treatment, - On 05/19/24, staff did not provide treatment, - On 05/20/24, staff provided treatment, - On 05/21/24, staff provided treatment, - On 05/22/24, staff did not provide treatment, - On 05/23/24, staff did not provide treatment. D. Record review of R #17's Hospice Care notes, dated 05/14/24 through 05/23/24, revealed hospice completed wound care treatment, as follows: - On 05/14/24, hospice provided treatment. - The notes did not contain any more documentation regarding wound care. E. On 05/22/24 at 10:50 a.m., during an interview, the Assistant Director of Nursing (ADON) stated he was responsible for the resident's wound care every Thursday. The ADON stated the facility did not have a designated wound care staff who provided wound care, but they ensured the care was provided by the RN's that were on shift. The ADON stated R #17's wound seemed to clear up for a day or two then the wound would appear again due to breast cancer. F. On 5/23/24 at 2:00 p.m., during an interview with Interim Director of Nursing (IDON), she stated the first order stated the wound care would be completed daily, and the second order stated Hospice would provide wound care, as needed, every three days. She stated the expectation was for the nurse on the floor, the Director of Nursing (DON), or the ADON to discontinue an order due to there being two orders that contradicted one another.

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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** 35632 Based on observation, record review, and interview, the facility failed to meet professional standards of care for 1 (R #30) of 1 (R #30) resident reviewed for respiratory care by not changing the oxygen tubing. This deficient practice could likely lead to respiratory infections by the oxygen tubing becoming clogged due to condensation (a process where water vapor becomes liquid) or becoming dirty, leading to the reduced oxygen flow. The findings are: A. Record review of the face sheet indicated R #30 was admitted to the facility on [DATE]. Resident had a diagnosis of pneumonia on 02/22/24 and on 03/06/24. B. Record review of the physician orders for R #30, dated 06/07/23, revealed an order for oxygen, 1 to 4 liters per minute (LPM) via nasal cannula (thin tube that supplies oxygen through your nose), as needed (PRN) to maintain oxygen saturation (the amount of oxygen in the blood) above 90 percent (%). Further review revealed the orders did not indicate how often staff should change the resident's oxygen tubing. C. On 05/20/24 at 12:10 pm, an observation of R #30's oxygen tubing revealed the tubing was dated 03/31/24. D. On 05/20/24 at 12:16 pm during an interview, Nurse (N) #6 stated the oxygen tubing was dated 03/31/24 date. She stated there should be orders to change the tubing, and it should be changed weekly.

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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** 48645 Based on observations and interviews, the facility failed to: 1. Ensure the medication carts did not contain loose medications. 2. Ensure expired supplies were not kept with unexpired supplies in the medication room. 3. Fentanyl patches were destroyed immediately after removal and not stored in the medication cart. These deficient practices are likely to result in all 31 residents of the 200 and 300 halls, as identified on the census list provided by the facility Administrator on [DATE], receiving expired medication, having expired medical supplies used in their treatments, and in the mishandling or misuse of narcotic drugs. The findings are: Findings for loose medications found in medication carts. A. On [DATE] am at 9:10 am, during observation of the 300 hall medication cart, one white, circular tablet was loose under the medication cards (vertical cardboard and foil cards pre-filled with prescription medications for easy storage and dispensing) in the drawer of the cart. B. On [DATE] at 9:26 am, during an interview with Certified Medication Aide (CMA) #1, she stated loose medications should not be in the medication cart under the medication cards. CMA #1 further stated whoever is using the medication cart should check the cart for loose medicationsat the beginning of each shift. Findings for expired supplies stored with unexpired supplies. C. On [DATE] at 9:30 am, during observation of the 300 hall medication storage room, the following supplies were expired and stored with unexpired supplies: 1. Twenty Med Stream intravenous (IV) start kits expired [DATE]. 2. One hundred [NAME] Prevent HT safety needles, 18 gauge, expired [DATE]. D. On [DATE] at 9:33 am, during an interview with Licensed Practical Nurse (LPN #1), she stated the IV start kits and the needles were expired and should not be stored with unexpired supplies. LPN #1 further stated all employees should check the medication storage room for expired supplies. She stated staff should remove expired supplies from the storage room and give them to the charge nurse or Director of Nursing. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35632 Findings for fentanyl patches. E. Record review of the facility's Medication Administration: Topical Patch Procedure, revised ,d+[DATE], indicated the following: - Removal and disposition of a controlled medication transdermal (the application of a medicine or drug through the skin, typically by using an adhesive patch, so that it is absorbed slowly into the body) patch: Fold patch in half with the sticky sides together and dispose in a secured pharmaceutical wastes container per appropriate medical wastes management regulations and applicable federal/state law. Do not flush the patch down the toilet. F. On [DATE] at 10:45 am, during an interview with Nurse #4 she stated she just removed a fentanyl patch and put it in the medication cart until she was able to destroy it. She said there was not a second nurse available to destroy the patch immediately. Nurse #4 stated there was a form that nurses signed when they destroyed fentanyl patches, and two nurses had to sign and date the form when they destroyed the patch. G. On [DATE] at 10:58 am, during an interview with Assistant Director of Nursing (ADON), he stated it was not okay to store a fentanyl patch in the medication cart while the patch waited to be destroyed. He stated he was always available to assist a nurse with the destruction of a fentanyl patch, and the Director of Nursing (DON) was also available. The ADON stated there was a form they used when the nurses destroyed a fentanyl patch, and the two nurses should sign and date it. He stated they used the drug buster (deactivates and contains the active ingredients in non-hazardous medications) to destroy the patches. H. On [DATE] at 8:30 am, during an interview with the DON, she stated the for removing a fentanyl patch was for two nurses to sign and date the form, and then they put the patch in the drug buster. The DON stated that once the nurses removed a patch, they should destroy it immediately. She said they should not lock the fentanyl patch in the medication cart. She stated she was always available if a second nurse was needed to destroy a patch.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49196 Based on observation and interview, the facility failed to store food in accordance with professional standards when staff stored expired food in the facility's walk-in refrigerator. This deficient practice had the potential to negatively impact all 47 residents listed on the census provided by the Director of Nursing on [DATE]. If the facility fails to adhere to safe food storage practices, residents could likely to be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On [DATE] at 9:52 AM during an observation of the facility's walk-in refrigerator, three packages of tofu had an expiration date of [DATE]. B. On [DATE] at 9:52 AM during an interview, the facility's chef stated staff should throw out the expired tofu and not store it in the walk-in refrigerator. C. On [DATE] at 1:02 PM during an interview, the facility's Director of Dining Services stated staff used the food stored in the walk-in refrigerator for the facility's residents, and the kitchen staff should check the refrigerator daily for expired foods. He stated staff should throw out expired foods when they discover them.