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	11/17/2025

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

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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 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. Based on observations, interviews, and record review, the facility failed to ensure:- Staff entering the second-floor kitchen during meal service wore required hair restraints, which had the potential to affect 19 out of 19 residents on the second floor.This deficient practice increased the risk of food contamination which could lead to foodborne illness.The findings are: A. Record review of Facility Uniform Dining Services Policy, last revised November 2024, revealed hair must be pulled up and contained in a hair net, visor, and/or cap if it is long. B. On 08/11/2025 at 12:24 PM, observation revealed an Activities Staff member entered the kitchen without a hairnet to grab a wash rag. The staff member exited kitchen to clean a table and then re-entered kitchen without hairnet at 12:25pm to return the wash rag. Further observation revealed the Activities Staff member walked past the food that staff was serving to the residents. C. On 08/13/2025 at 10:00 AM, during an interview, the Activities staff member stated she did not wear a hairnet either time she entered the kitchen. Activities staff member stated she should wear a hairnet when entering the kitchen. D. On 08/13/2025 at 12:45 PM, during an interview, the Nutritional Services Manager (NSM) stated all staff should wear hairnets when entering kitchen for any amount of time.

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 - 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 record review, interview, and observation the facility failed to ensure professional standards of care for (R #19 and #46) of 2 (R #19 and #46) residents when staff failed to:- Obtain and enter wound care orders for the resident's wounds.- Put away a resident's fall mat after the resident got out of bed. If the facility fails to obtain and enter orders for wound care, then residents may not receive the care needed to improve their wounds. If staff fail to put away a resident's fall mat after they get out of bed, then the resident may not be able to access their bed or other areas of their room. The findings are: R #46A. Record review of R #46's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 08/14/25, indicated the resident was admitted to the facility on [DATE] with the following diagnoses:- Major joint replacement,-Fracture of the right femur (long bone that connects the hip to the knee),-Type II diabetes (DM2; a disease in which the body cannot make or properly use insulin) B. Record review of R #46's wound assessments revealed the resident had the following wounds on admission: -Right lateral thigh surgical wound with staples dated 08/08/25,-Surgical wound with staples front right knee dated 08/08/25,-Surgical front right trochanter (hip) with staples dated 08/08/25,-Skin tear/laceration to the right lower elbow dated 08/12/25,-Skin tear right upper arm laceration, dated 08/12/25. C. Record review of R #46's physician orders, dated 08/08/25, revealed there were not any orders for wound care. D. Record review of R #46's Treatment Administration Record (TAR), dated 08/08/25 to 08/11/25, revealed staff did not document they provided any wound care to the resident. E. On 08/11/25 at 2:50 pm, during an observation and interview, R #46 had a bandage on her left arm. The bandage was slightly soiled and dirty. The bandage did not have a date on it. R #46 stated she fell before coming to the facility. R #46 stated she had surgery and was bruised all over from the fall. She stated her bandage on her left arm was changed yesterday on 08/10/25 by the nurse. F. On 08/11/25 at 3:11 pm, during an interview, Nurse #3 stated she was aware of R #46's wounds, because she provided wound care for R #46. Nurse #3 stated she did not see any wound care orders in the resident's physician orders on admission. She stated the admitting nurse should enter the orders into the electronic medical record on admission. She stated staff should call the provider or on-call provider if there were not any orders on admission. Nurse #3 stated she brought up that R #46 did not have any wound orders to the Assistant Director of Nursing (ADON). Nurse #3 stated if she provided wound care to the resident, then there should be wound care orders in the resident's record. G. On 08/11/25 at 3:30 pm, during an interview, the ADON stated she did not review R #46's medical record, but she was aware R #46 did not have wound care orders in the electronic medical record. She stated Nurse #3 asked her about the resident's wound care orders. The ADON stated it was the responsibility of the admitting nurse to enter orders into the electronic medical record on admission. She stated if a nurse provided wound care, then there should be orders for wound care. H. On 08/12/25 at 3:04 pm, during an interview, the Director of Nursing (DON) stated she expected a new resident to receive a full skin check. She stated staff should take pictures of any wound and measure them. She stated staff should enter wound orders into the electronic medical record. She stated if there were not any wound orders from the hospital discharge paperwork, then staff should call the physician or on-call physician to get some orders. She stated she assumed wound care was completed because the resident had a wound dressing on. The DON stated wound care should not be provided without physician orders. R #19I. Record review of R #19's medical record revealed an admission date of 07/18/25 with the following diagnoses:-Hypertension (high blood pressure),-Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),-Atrial fibrillation (A-fib; irregular heart rhythm),-Metabolic encephalopathy (a brain dysfunction caused by an underlying condition that affects your metabolism). J. Record review of R #19's physician orders, dated 07/18/25, revealed an order for fall precautions/restrictions. K. Record review of R #19's care plan, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/19/25 revealed the following:- R #19 was a fall risk.- The resident had six falls since admission.- Interventions: floor mats on floor next to the bed. L. On 08/12/25 at 9:30 am, an observation revealed fall mats on the floor in R #19's room, and R #19 was not in bed. M. On 08/12/25 at 9:45 am, during interview, Certified Nurse Assistant (CNA) #5 stated the resident's fall mats were always on the floor. She stated she did not remove them when the resident was out of bed. N. On 08/14/25 at 12:20 pm, during an interview, ADON stated fall mats should not be on the floor when the resident was not in bed.

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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. Based on record reviews and interviews, the facility failed to ensure resident records were complete when staff failed to document resident weights into the residents' medical record for 2 (R #45 and #46) of 2 (R #45 and #46) residents. If staff do not document necessary resident information into the medical records, then the resident may not receive the services needed to maintain or achieve optimum health. The findings are: R #45A. Record review of R #45's face sheet revealed an admission date of 08/07/25 with the following diagnoses:- Fracture (break) of the left lower leg,-Chronic Obstructive Pulmonary Disease (COPD; lung disease),- Hypertension (high blood pressure).B. Record review of R #45's physician orders, dated 08/08/25, indicated an order for daily weights, starting on admission for 3 days and then weekly for 4 weeks. C. Record review of R #45's weights revealed staff documented one weight for R #45 on 08/10/25. R #46D. Record review of R #46's face sheet revealed an admission date of 08/08/25 with the following diagnoses:-Fracture of the right femur (break in the long bone that connects the hip to the knee)-Type II diabetes (DM; a disease in which the body cannot make or properly use insulin),-Acute kidney failure (impaired kidney function). E. Record review of R #46's physician orders, dated 08/08/25, indicated an order for daily weights, starting on admission for 3 days and then weekly for 4 weeks. F. Record review of R #46's weights revealed staff documented one weight for R #45 on 08/08/25.G. On 08/14/25 at 9:03 am, during an interview, Nurse #8 stated the physician liked to monitor resident weights, so every new admit had an order to weigh daily for three days. Nurse #8 stated they documented the weights on a piece of paper and checked it for consistency before it was entered into the system. Nurse #8 stated the Certified Nursing Assistants (CNA) were delegated to do the weights. Nurse #8 stated the Nurse, Assistant Director of Nursing (ADON), or the Dietician would enter the weights into the system. H. On 08/14/25 at 9:13 am, during an interview, CNA #6 stated the Nurse told her which residents needed to be weighed. She stated they documented the weights on a piece of paper and gave them to the Nurse when completed. She stated the Nurse reviewed the weights and entered the weights into the system. CNA #6 stated she thought she weighed R #46 and R #45 three days in a row.I. On 08/14/25 at 12:20 pm, during an interview, the ADON stated all weights should be completed as ordered and put into the system. The ADON stated the weights went to the Dietician to make sure the weights are accurate. She stated the Dietician or the Nurse entered the weights into the system after they were verified.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete an annual performance/competency review for 1 (Certified Nurse Assistants - CNA #5) of 5 (CNAs #2, #3, #4, #5 and #10) CNAs. If staff do not receive 12 performance/competency reviews annually, then they may not maintain the competencies necessary to perform daily tasks of providing care and services to meet the needs of all residents. The findings are:A. Record review of the facility's staffing competencies from August 2024 to August 2025 revealed the facility did not perform staffing competencies on a yearly basis for CNA #5. The facility conducted staffing competency on hire only. B. On 08/11/25 at 10:30 am, during an interview, the Administrator stated they did not currently have a Nurse Educator, and the Assistant Director of Nursing (ADON) was in charge of the CNA competencies. C. On 08/13/25 11:30 am, during an interview, CNA #5 stated she did not have competencies completed, and she could not remember doing them when she was hired. D. On 08/14/25 at 12:20 pm, during an interview, the Assistant Director of Nursing (ADON) stated competencies were completed for new hires, but the facility did not complete yearly competencies with the staff.

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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 record reviews and interviews, the facility failed to schedule an annual appointment for dental services for one (R #6) of one (R #6) residents. This deficient practice could likely result in an increased risk of developing serious dental issues like tooth loss and infection, which can require extensive treatment. The findings are:A. Record review of the facility's Dental Services & Oral Screening Policy, dated February 2023, revealed the following:- Each resident will be offered the opportunity to receive an annual oral screening by the contracted facility dentist.- Residents will be assisted, when necessary or if requested, in making routine and annual appointments and with arranging transportation to and from dental location.- The resident will have the right to select the dental care provider of their choice. The facility will inform the resident as to how the dental care provider can be contacted.- Facility staff will track when resident annual exam is due and notify family and/or the facility dentist. B. Record review of R #6's Face Sheet revealed R #6 was admitted to the facility on [DATE]. C. Record review of R #6's Electronic Health Record (EHR), undated, revealed R #6 did not have a scheduled dental appointment or a dental service visit during the past 12 months. D. Record review of a written statement provided by the administrator, dated 08/13/25, revealed the Medical Records Director (MRD) stated R #6 used a geriatric wheelchair and the facility's transportation could not transport geriatric chairs. The MRD stated she attempted to schedule R #6 for dental services with a mobile dental company, but those attempts were unsuccessful due to dental company phone number was unreachable. E. On 08/11/25 at 12:46 pm, during an interview, R #6 stated he did not recall the last time he went to a dentist for routine dental exam. He stated he was interested in having his teeth and mouth checked. He stated staff did not offer him a dental appointment. F. On 08/13/25 at 09:50 am, during an interview, the Director of Social Services (DSS) stated R #6 went over a year without having a dental appointment. She stated she should have scheduled R #6 for a dental appointment within the past 12 months. G. On 08/13/25 at 11:50 am, during an interview, the Director of Nursing (DON) stated she expected the DSS to schedule R #6 for his annual dental exam.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record reviews, and interviews, the facility failed to ensure a call light was within reach for 1 (R #4) of 1 (R #4) resident. If the facility is not ensuring the call light is within residents' reach, then residents may be unable to request immediate assistance when needed.The findings are: A. Record review of the facility's Call Lights Policy, dated October 2024, revealed staff were instructed to place the call light within easy reach of the resident while in bed or a chair. B. On 08/11/25 at 11:27 am, observation revealed R #4's call light hung out of R #4's reach while the resident lay in bed watching TV. C. On 08/13/25 at 9:39 am, during an interview, Certified Nurse Assistant (CNA) #1 stated call lights should be within residents' reach. She stated R #4 needed the call light to request assistance when needed. D. On 08/13/25 at 11:50 am, during an interview, the Director of Nursing (DON) stated he expected all staff to check R #4's call light when they went into the resident's room. The DON stated if a call light hung off R #4's bed, then staff should pick it up and place it by the resident. The DON stated staff should use a clip to ensure the call light stayed attached to R #4's bed and within the resident's reach. E. On 08/14/25 at 9:21 am, during an interview, Nurse #1 stated call lights should be within the resident's reach. He stated Nurses and CNAs should have noticed R #4's call light was out of reach and should have clipped to R #4's bed.