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	04/01/2024

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 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** 35632 Based on interview and record review, the facility failed to notify the power of attorney (POA; a designation given to an agent to handle financial or medical acts on someone else's behalf) and the Nurse Practitioner (NP) of a fall for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for falls. This deficient practice could likely cause a breakdown in resident care if the NP is not notified of all falls and the family is left feeling uninformed and frustrated about their loved ones care. The findings are: A. Record review of the face sheet for R #1 revealed he was admitted to the facility on [DATE]. Further review revealed the resident's POA was Family Member #3. B. Record review of the nursing progress note for R #1, dated 11/07/23 at 3:53 pm, revealed the nurse reported R #1 fell in the dining room while playing Bingo. The nurse stated she checked R #1. R #1 did not hit his head and did not complain of any pain. The resident's range of motion (the extent or limit to which a apart of the body can be moved around a joint or a fixed point) was fine. R #1's family member #1 and family member #2 were with him when he fell . C. Record review of R #1's medical record revealed the staff did not notify the resident's POA or the Nurse Practitioner of the fall on 11/07/24. D. On 04/02/24 at 11:30 am, during an interview with the Director of Nursing (DON), she stated staff should always inform the POA of any falls. She stated staff should notify the POA even if a family member was present when a fall occurred, if that family member was not the POA. E. On 04/02/24 at 11:05 am, during an interview with Nurse Practitioner (NP) she stated she did not write any notes about R #1's fall on 11/07/23, which indicated staff did not make her aware of R #1's fall.

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450 Based on record review and interview, the facility failed to follow a physician's order for 1 (R #2) of 1 (R #2) residents reviewed for medication administration. This deficient practice could likely cause staff to administer a medication to a resident when the medication is not necessary. The findings are: A. Record review of R #2's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 03/01/2024, revealed the following: - The resident was admitted to the facility on [DATE]; - The resident was diagnosed with Parkinson's disease (a neurodegenerative disorder that affects the brain and worsens over time as cells in the brain that produce dopamine stop working or die). B. Record review of R #2's Hospice Admission Orders, dated 03/23/24, revealed an order for morphine sulfate, 20 milligrams (mg)/millilters (ml), 0.25 ml by mouth every four hours as needed for pain or shortness of breath. C. Record review of R #2's medical record revealed a physician order, dated 03/23/24, for morphine sulphate 20 mg/ml, 0.25 ml liquid: 20 mg. Amount to administer 0.25; orally. Frequency: Every four hours. Special instructions: Administer every four hours as needed for pain or shortness of breath. Diagnosis: pain. D. Record review of the Medication Administration Record (MAR) for R #1 revealed the following: - On 03/23/24, staff administered morphine sulphate to the resident at 4:00 pm and at 8:00 pm. - On 03/24/24, staff administered morphine sulphate to the resident at 12:00 am, 4:00 am, and at 8:00 am. E. Record review of nursing notes, dated 03/24/24, revealed .daughter is extremely upset due to the fact that resident has been given morphine every 4 hours instead of PRN . writer removed the order for morphine with the scheduled times and left the PRN order. B. On 03/28/24 at 9:21 am during an interview with the daughter of R #2, she reported that due to her father's condition, he began hospice services on 03/23/24, which included a PRN order for morphine when he experienced pain or shortness of breath. She stated she called the facility on 03/24/24 to check on her father, and the nurse informed her that he was resting due to the administration of morphine. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 03/29/24 at 10:23 am, during an interview with the Director of Nursing (DON), she stated R #2's initial order is for morphine sulfate was 20mg/ml by mouth every four hours as needed for pain or shortness of breath; however, the agency nurse transcribed the order incorrectly. She stated the agency nurse entered the order as every four hours scheduled, and staff administered the morphine to R #2 as scheduled, every four hours. The DON stated staff administered three doses before they found the order was supposed to be as needed and not scheduled. She stated the resident should not have received any doses of morphine.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to provide behavioral health treatment for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for insomnia. This deficient practice could likely cause a resident to have increased agitation, restlessness, and falls. The findings are: A. Record review of the face sheet for R #1 revealed R #1 was admitted to the facility on [DATE] with a diagnosis of dementia (a condition where the patient experiences the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with agitation and schizophrenia (thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, and decreased participation in daily activities). Further review revealed R #1 discharged the facility on 11/21/23. B. Record review of the nursing progress notes for R #1 revealed the following: 1. On 10/30/23, staff documented staff monitored the resident frequently throughout the night. The resident slept for few hours but was awake most of the night. 2. On 11/04/23, staff documented R #1 was combative and did not sleep through the night. R #1 screamed for help while he was in bed. The resident kicked and hit staff. 3. On 11/08/23, staff documented staff monitored R #1 at the nurses station, because he continued to try and get out of his wheelchair and cussed at staff. R #1 requested to go bed at 10:00 pm. R #1 slept for 3 hours and started screaming. Staff responded and found R #1 naked. The resident urinated in his bed. When staff tried to change him, the resident started kicking, yelling, and telling staff to get out of his room. 4. On 11/11/23, staff documented the resident was verbally abusive and slept in chair all night. 5. On 11/13/23, staff documented R #1 was very easily agitated frequently. He self-propelled in his wheel chair. Staff constantly redirected throughout shift. Resident stayed awake most of the shift in agitated manner. Resident tried to self-propel himself into other resident's rooms, he became very angry, and cursed loudly as CNAs gently wheeled him out of the resident's rooms. 6. On 11/21/23, staff documented the resident was rude and combative with staff in the evening. R #1 was up throughout the night. C. Record review of the current physician orders for R #1 revealed the resident did not have an order to address his lack of sleep or behaviors throughout the night. D. On 03/28/24 at 5:21 pm during an interview with Nurse #1, she stated R #1 was aggressive, restless, and would not sleep well through the night. E. On 04/02/24 at 11:05 am during an interview with the Nurse Practitioner, she stated she was not aware R #1 had insomnia issues and often did not sleep through the night. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 04/02/24 at 11:35 am during an interview with the Director of Nursing (DON), she stated R #1 did not have a referral for a behavioral health consult while he was at the facility; but when R #1 was at his previous facility, behavior health was part of the care R #1 received. She stated R #1 did not have an order for anything to treat for his insomnia.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to monitor behaviors for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for the use of psychotropic medications. This deficient practice could likely result in residents continuing to exhibiting behaviors of agitation that are not remedied . The findings are: A. Record review of the face sheet for R #1 revealed R #1 was admitted to the facility on [DATE] with a diagnosis of dementia (a condition where the patient experiences the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with agitation and schizophrenia (thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, and decreased participation in daily activities). Further review revealed R #1 discharged the facility on [DATE]. B. Record review of R #1's nursing progress notes revealed the following: 1. On [DATE], staff documented staff monitored the resident frequently throughout the night. The resident slept for few hours but was awake most of the night. 2. On [DATE], staff documented R #1 was combative and did not sleep through the night. R #1 screamed for help while he was in bed. The resident kicked and hit staff. 3. On [DATE], staff documented staff monitored R #1 at the nurses station, because he continued to try and get out of his wheelchair and cussed at staff. R #1 requested to go bed at 10:00 pm. R #1 slept for 3 hours and started screaming. Staff responded and found R #1 naked. The resident urinated in his bed. When staff tried to change him, the resident started kicking, yelling, and telling staff to get out of his room. 4. On [DATE], staff documented the resident was verbally abusive and slept in chair all night. 5. On [DATE], staff documented R #1 was very easily agitated frequently. He self-propelled in his wheel chair. Staff constantly redirected throughout shift. Resident stayed awake most of the shift in agitated manner. Family was aware of resident's behaviors and inability to sleep at night often per day staff, but they did not want him taking any as needed (PRN) medications despite his constant agitated yelling and cursing outburst behaviors, which could be stressful on himself and potentially lead to an even more increased risk for falls. Resident tried to self-propel himself into other resident's rooms, he became very angry, and cursed loudly as CNAs gently wheeled him out of the resident's rooms. Resident continued to be monitored closely by staff as he was a very high risk for falls and has reportedly fallen in the past. 6. On [DATE], staff documented R #1 fell out of a recliner as he attempted to stand up unassisted. 7. On [DATE], staff documented the resident was rude and combative with staff in the evening. R #1 was up throughout the night. C. Record review of the current physician orders for R #1 revealed the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Physician order, dated [DATE] to [DATE], for gabapentin capsule (an anticonvulsant and nerve pain medication); 100 milligrams (mg). Amount to administer: one orally, three times a day. For schizophrenia. 2. Physician order, dated [DATE] to [DATE], for olanzapine tablet (an antipsychotic medication, often used to treat schizophrenia); 2.5 mg. Amount to administer: one tablet orally at bedtime. For schizophrenia. 3. Physician order, dated [DATE] to [DATE], for Prozac capsule (a selective serotonin reuptake inhibitor; a type of medication that can treat depression by by increasing levels of serotonin in the brain); 10 mg. Amount to administer: one tablet orally once a day. For depression. D. Record review of R #1's care plan revealed the following entries: 1. An entry dated [DATE]. - R #1 received antipsychotic medication related to dementia with delirium/agitation. - Approaches: Assess if the resident's behavioral symptoms presented a danger to the resident or others. Intervene as needed. Monitor resident's behavior and response to medication: Monitor for drowsiness /over sedation, delayed reaction, impaired cognition/behavior, disturbed balance/gait/positioning ability, slurred speech, sleep disturbance, tardive dyskinesia symptoms symptoms (repetitive, involuntary movements, such as grimacing and eye blinking caused by long-term use of some psychiatric drugs). Every shift. Monitor resident's functional status, document change, and report to provider. Review for continued need at least quarterly. Every shift. E. Record review of Treatment Administration Record (TAR), for the month of [DATE], revealed the following physician orders: 1. Dated [DATE]: Monitor resident's behavior and response to medication. Monitor for drowsiness/over sedation, delayed reaction, impaired cognition/behavior, disturbed balance/gait/positioning ability, slurred speech, sleep disturbance, tardive dyskinesia. Every shift. -Staff initialed the TAR to indicate they monitored R #1 for behaviors; however, the TAR did not contain documentation to indicate if a behavior occured or not. 2. Dated [DATE]: Anti-psychotic medication use olanzapine. Observe closely for significant side effects. Common side effects: Sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal reaction (involuntary movements that you cannot control), weight gain, edema (swelling caused by too much fluid trapped in the body's tissues), postural hypotension (when a person's blood pressure drops when they move from lying down to sitting up, or from sitting to standing), sweating, loss of appetite, urinary retention. Every shift. Diagnosis: depression, unspecified. - Special attention for: Tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice (may occcur if the liver cannot efficeintly process red blood cells as they break down. Symptoms include yellowing of the skin and whites of the eyes.) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Document 0 if none noted, document 1 if side effect(s) noted. If side effects present indicate in progress note with follow-up. - Staff documented 0 for all observations on [DATE] through [DATE]. 3. Dated [DATE]: Monitor and document any of the following behaviors every shift: Tearfulness, self-isolation related to use of psychotropic medication. - Document Frequency. 0: Behaviors did not occur, 1: Behaviors occurred once, 2: Behaviors occurred more than once. - Staff documented 0 for all behaviors on [DATE] through [DATE]. - Document the ability to redirect. 0: Redirection did not occur, E: Resident was easy to re-direct, D: Resident was difficult to re-direct. - Staff documented 0 for all redirection on [DATE]-[DATE]. 4. The TAR did not contain documentation staff monitored the resident for agitation, yelling, cursing, and combativeness. F. On [DATE] at 5:21 pm during an interview with Nurse #1, she stated R #1 was aggressive, restless, and would not sleep well through the night. G. On [DATE] at 9:22 am during an interview with Nurse #2, she stated R #1 was noncompliant. The nurse said the resident would try to get up and walk around. R #1 would try to get out of bed unassisted. R #1 would try to leave the unit. She said some days he would take his medications, and some days he would refuse. Nurse #2 said sometimes the resident would bother other residents. She stated most of the resident's falls occurred when he tried to get up unassisted.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40795 Based on observation, interview, and record review, the facility failed to ensure resident furnature was in operable working condition when they continued to use a broken recliner for 1 (R #1) of 3 (R #1, 2, 3) residents reviewed for falls. This deficient practice could likely result in an injury if the reclining chairs are not in good operable condition. The findings are: A. On 03/29/24 at 11:32 am, during an observation of the recliners near the nurse's station, one recliner was broken. The foot rest was not attached to the mechanism that extended to raise and support the feet. B. On 03/29/24 at 11:35 am and 04/02/24 at 11:30 am, during an interview, the Director of Nursing (DON) stated there were recliners in the memory care unit for the residents to use. She said the foot rest on one of the recliners did not lock when in the elevated position, and the foot rest would fall from the elevated position. The DON stated staff would place a foot stool under the foot rest so it would stay in the elevated position while a resident sat in the chair. The DON confirmed the broken recliner should not be on the floor for resident use.