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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325127	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites Rio Vista	2410 19th Street SE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, the facility failed to ensure medical records consistently reflected the correct code status for 1 (R #5) of 3 (R #5, #6, and #7) residents. If code status is not accurately documented in resident records, then the resident is at risk of a life-threatening medical error. The findings are: A. Record review of R #5's face sheet revealed an admission date of 06/11/25. Further review revealed the resident's code status was not documented in the record. B. Record review of R #5's hospital discharge documentation, dated 06/07/25, revealed a code status of Do Not Resuscitate (DNR; lifesaving measures are not desired). C. Record review of R #5's New Mexico Medical Orders for Scope of Treatment (NM MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form, dated 06/11/25, revealed a DNR code status. D. Record review of R #5's Care Plan, dated 06/23/25, revealed a Full Code Status. E. On 08/21/25 at 8:30 am, during an interview, Family Member (FM) #1 stated a nurse told her R #5 was a full code status when she inquired about R #5's code status during the admission process. FM #1 stated she was concerned, because she was aware R #5's status was DNR when she was discharged from the hospital. F. On 08/21/25 at 2:33 pm during an interview, the Director of Nursing (DON) stated the facility presumed residents were a Full Code status if nothing was documented on the resident's face sheet. The DON verified the conflicting information within R #5's records and stated it was the facility's expectation for code status to be consistent throughout the medical record.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain the resident environment free from the potential for accidents and hazards when staff left: - An electrical junction box unsecured. - Electrical cords stretched across the hallway floor. - A fire alarm control panel open. These failures had the potential to affect all residents in the facility. If the facility fails to secure electrical panels and equipment and to remove tripping hazards from resident areas, then residents are at risk of injury. The findings are: A. Review of the facility’s Hazardous Areas, Devices, and Equipment policy, revised 2018, revealed the following: - All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. - Hazard was defined as anything in the environment that has the potential to cause injury or illness. - Examples included: Equipment and devices left unattended or malfunctioning, Open areas or items that should be locked when not in use, Irregular floor surfaces (cords, buckled carpeting, etc.). Any element of the resident environment that has the potential to cause injury and is accessible to a vulnerable resident. B. On 08/21/2025 at 12:00 p.m., observation revealed a small white electrical box mounted on the wall at the end of the hallway. The door of the box was unsecured and partially open, which exposed the internal wires and circuit boards. The box was located within reach of residents who utilized the hallway handrail. Further observation revealed staff were not present in the area. C. On 08/21/2025 at 12:01 p.m., observation revealed multiple cords for a power wheelchair, including a black power cord and a white coaxial cable attached to a battery box, lay unattended across the carpeted hallway floor. There were no staff or residents in the hallway. D. On 08/21/25 at 12:15 p.m., observation revealed the facility’s fire alarm control panel in the main hallway was open, and the wires and control components were exposed. The panel was accessible to residents, and staff were not present in the immediate area. F. On 08/21/25 at 3:00 p.m., observation of R #2’s room revealed a large kitchen knife on the desk and an open can of WD-40 sat on the resident's nightstand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 08/21/25 at 3:00p.m., during an interview, R #2 stated the large kitchen knife was to cut up his pineapple. He stated he brought it when he came to the facility. R #2 stated the WD-40 was for his wheelchair. G. On 08/21/25 at 1:25 p.m., during an interview, the Assistant Director of Nursing (ADON) stated the fire alarm control panel should be shut and locked at all times; because residents could open it, push buttons, and possibly disarm the alarm system. He stated R #2 should not have a large kitchen knife in his room. He stated it was a hazard for the resident to have the knife in his room; because he could injure himself, staff, or other residents. The ADON stated the can of WD-40 was for R #2’s wheelchair. He stated he took the WD-40 out of R #2’s room, because it could be used to harm residents or staff. H. On 08/21/25 at 1:40 p.m., during an interview, the Maintenance Director (MD) stated the electrical boxes and fire alarm panel should be kept closed and secured at all times to prevent tampering and injury. He stated unsecured cords across the floor presented a fall hazard to the residents.