STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 Based on record review and interview, the facility failed to ensure that 1(R #1) of 4 (R #,d+[DATE]) residents reviewed received treatment and care in a timely manner and in accordance with professional standards of practice when the facility failed to identify a change in condition and adequately assess R #1 when she informed the nurse that she thought she was having a stroke and then demonstrated unexplained significant weakness during transfer. Several hours later, R #1 became unresponsive and hypoxic (low oxygen in blood). This deficient practice likely resulted in R #1 experiencing a delay in treatment. The findings are: A. Record review of R #1 face sheet revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: 1. Acute and chronic respiratory failure, with hypoxia (low oxygen) or hypercapnia (too much carbon dioxide in blood). 2. Type 2 Diabetes Mellitus with hyperglycemia (a group of diseases resulting from damaged or malfunctioning of nerves that causes weakness, numbness, and pain in hands and feet). 3. Morbid obesity. 4. Hyperlipidemia (high levels of fats in the blood). 5. Depression. 6. Sleep apnea. 7. Nicotine dependence. 8. Essential hypertension (high blood pressure). 9. Myocardial infarction type 2 (condition contributes to imbalance between oxygen supply and demand) 10. Paroxysmal Atrial fibrillation (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 0684 Level of Harm - Actual harm Residents Affected - Few	11. Chronic obstructive pulmonary disease (COPD: a disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough). 12. Displaced fracture of surgical neck of left humerus (closed fracture). 13. Need for assistance with personal care. B. Record review of R #1's nursing progress notes revealed the following: 1. On [DATE] at 5:30 pm: Pt (patient) came in from facility transport in a wheelchair accompanied by her husband. Her speech is clear, she can stand and walk some with one person assist and uses a cane but mostly in a wheelchair, cheeks are pink, eyes are 2 mm (millimeters) bilateral, she has lower dentures only, she has a broken left should [shoulder] that is a closed fracture and she said they cannot do surgery. She has CHF (Congested Heart Failure), COPD,on O2 (oxygen) NC (nasal cannula) at ,d+[DATE] liters, with edema on heart and lungs, skin is clear with each lower leg having a healed veinous ulcer. 2. On [DATE] at 12:03 pm: Pt was sitting at the dining room table and said she thought she was having strokes [sic] (damage to brain from interruption of its blood supply). I asked if she had them before and she said yes. I asked how many and she said all of the time. I asked again, how many, which she could not give a number. Her vs (vital signs) are ,d+[DATE]; 98.0;85% on 4 L (liters) (she said she gets low in the 70s at home) I asked if she wanted me to call an ambulance and her go to the hospital and she said she wanted a paramedic to tell her if she needed to go or not and I said they cannot legally tell you what to do because it is your decision. There are no signs of a stroke or TIA (transient ischemic attack: brief stroke). She has no weak movement in her arms, no slurred speech, no blurry vision. The nursing note did not contain documentation staff contacted the physician. 3. On [DATE] at 3:30 pm: Resident requested to go to bed from wheelchair. CNA attempted to transfer resident, resident was unable to stand and help with transfer. This nurse came to assist resident. Unable to stand resident for transfer, so resident was assisted into the floor and then transferred to bed via hoyer lift (a mobility tool used to transfer). 4. On [DATE] at 5:44 pm: Situation: The Change In Condition (CIC) reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Unresponsiveness. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] -[DATE] 17:20 Position: Lying r (right)/arm - Pulse: P 65 - [DATE] 17:20 (5:20 pm) PulseType: Regular - RR: R 20.0 - [DATE] 17:20 - Temp: T 97.6 - [DATE] 17:20, Route: Forehead (non-contact) - Weight: W 244.0 lb - [DATE] 16:13 (4:13 pm) Scale: Wheelchair - Pulse Oximetry: O2 65.0 % - [DATE] 17:20, Method: Oxygen via Nasal Cannula (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 0684 Level of Harm - Actual harm Residents Affected - Few	- Blood Glucose: BS 95.0 - [DATE] 17:20. C. Record review of the Patient Care Report, dated [DATE], revealed, Responded emergency with Engine -5 crew re: (regarding) unresponsive 63 YOF (year old female). Upon our arrival, the nursing staff reports the pt was fine about an hour and a half ago and when she went to check on her, she was not responsive, she was breathing inadequately, and her blood pressure was very high; that she placed a high flow oxygen non-rebreather mask on the pt and called for ems. We found the pt lying supine (face up) on her bed in her room, her husband was also present. D. Record review of R #1's hospital emergency note, dated [DATE], revealed R #1 presented to the emergency department with acute hypoxemic respiratory failure (hypoxia of hypercapnia) and unresponsive. R #1 was intubated and sedated on presentation. R #1 on 100 percent (%) oxygen on ventilator was in the low 80s (Normal range is 95% or higher), and R #1 was in acute renal failure and hypotensive. R #1's spouse and son were at bedside and emergency room physician spoke with them about R #1's code status [do not resuscitate]. Spouse and son were in agreement to stop the sedation and to extubate (remove tube). emergency room physician proceeded with extubating, and R #1 expired at 9:55 pm [on [DATE]]. E. On [DATE] at 10:00 am and [DATE] at 3:41 pm during interview, R #1's spouse stated he spoke with R #1 around 11:00 am on [DATE], and she stated she was going to get a shower. He stated he tried calling R #1 later, and there was no answer. After work at around 3:30 pm, he went to the facility and found her unresponsive. He stated, she was blue, unconscious, and cold. He stated R #1 was not wearing her oxygen, and he called out for the charge nurse [License Practical Nurse LPN #1]. He stated the charge nurse was handling medications outside R #1's room door. He stated LPN #1 took R #1's vitals and called the paramedics. He stated it took 30 to 40 minutes for the paramedics to arrive. R #1's spouse stated an unknown staff member spewed out that R #1 almost passed out in the shower. R #1's spouse stated, I think they worked the hell out of her in therapy and she loss consciousness and they put her in the room and left her like that. F. On [DATE] at 9:30 am and [DATE] at 315 pm during interview with Certified Nurse Aide (CNA) #1, she stated she was R #1's CNA on [DATE], and R #1 was fine earlier in the day; laughing, talking, excited about getting a shower, talking on the phone and had breakfast. CNA #1 also reported she observed R #1 walking in her room independently [without her walker] in the morning. CNA #1 confirmed R #1 was a one person assist. CNA #1 stated she gave R #1 a shower with no issues and later in the day she observed the resident sleeping in her chair. CNA #1 stated, she looked like she was going to fall over. CNA #1 stated she woke R #1 up and offered to transfer her to bed. She stated R #1 was talking and responding, but R #1 reported she was tired. CNA #1 stated many residents get tired after lunch, and she thought R #1 was exhausted from therapy [at 10:00 am] and the shower. CNA #1 stated the resident was dead weight when she transferred R #1 from her wheelchair to the bed, and she called for LPN #1 to assist with the transfer. CNA #1 reported she told LPN #1, I said something is wrong with her. [Name of LPN #1] said it was probably her oxygen. CNA #1 confirmed R #1 wore her oxygen during the shower. CNA #1 stated the resident was connected to the in room oxygen concentrator [via nasal cannula] and after she was transferred to bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 0684 Level of Harm - Actual harm Residents Affected - Few	G. On [DATE] at 11:30 am and [DATE] at 2:32 pm and at 4:52 pm during interview with LPN #1, she stated that [DATE] was the only day she took care of R #1. She stated R #1 was alert and oriented, took her medication, and went to the therapy that day. LPN #1 stated earlier in the day she saw R #1 wheeling (in wheelchair) herself in the hallway. LPN #1 stated she heard from therapy the resident was a one person transfer. LPN #1 stated she was in the resident's room after lunch and assisted R #1's roommate when CNA #1 asked her to assist in transferring R #1. LPN #1 stated that R #1 had scooted herself to the edge of the wheelchair and was too weak to assist CNA #1 with the transfer. LPN #1 stated she came over to assist. LPN #1 stated CNA #1 was trying to hold up R #1 but due to R #1 being lower than the wheelchair seat, it was easier to assist her to the floor than to pick her back up to sit in the wheelchair, so they [LPN and CNA] assisted R #1 to the ground. LPN #1 stated they used a hoyer lift to move the resident from the floor to the bed. LPN #1 stated R #1 stated she was tired, but LPN #1 did not check the resident's vitals. LPN #1 stated R #1 did not hit her head. LPN #1 stated she was passing medications outside of R #1's room and could hear her sleeping/snoring. LPN #1 stated the resident did not appear to be in any distress. LPN #1 stated a couple hours after putting R #1 in bed, her husband came to visit. She said the husband tried to talk to the resident and wake her up, but R #1 did not respond. LPN #1 said the husband called for assistance. LPN #1 said she checked the resident's vitals and could see that her oxygen saturation (blood oxygen level) was 65%. LPN #1 stated, All her (the resident's) vitals were okay, but she wasn't responding to him (her husband). LPN #1 confirmed R #1 wore her oxygen cannula when she was found unresponsive, but she pulled the oxygen from the crash cart so that she could push more oxygen. LPN #1 stated she called 911. LPN #1 stated the paramedics arrived shortly afterwards. LPN #1 confirmed she was aware R #1 passed after being transferred to the hospital. LPN #1 stated she was now aware that R #1's weakness during transfer should have been considered a change in condition. H. On [DATE] at 4:50 pm interview with Physical Therapy Director (PTD), he stated therapy saw R #1 the morning of [DATE], before her shower; and they did extended stretches with her for her shoulder. He stated R #1 seemed like a good therapy candidate, and it was determined she only needed one person to assist with transfers. The PTD did not identify any concerns during her session on [DATE]. I. On [DATE] at 11:30 am interview with Director of Nursing (DON), she stated it was expected staff would complete a change of condition when R #1 was unresponsive. The DON confirmed that staff did not complete the change of condition documentation or notification to the Medical Doctor. J. On [DATE] at 9:42 am during interview with the Assistant Director of Nursing (ADON) regarding R #1, she stated staff should have sent R #1 to the hospital for evaluation when the resident told the nurse she thought she was having a stroke ([DATE]), even though the resident's vital were okay. The ADON stated the staff also should have notified the Physician due to R #1's history and diagnosis. Regarding R #1 being weak during transfer on [DATE] and needing the use of a hoyer, ADON stated this is considered a fall and the nurse should have assessed the resident, including taking her vitals. The ADON stated both incidents, the one on [DATE] [telling nurse she was having a stroke] and the one on [DATE] [being weak and needing hoyer transfer], would be considered change in conditions prior to the R #1 being found unresponsive. 48960

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33768 This was cited as past non-compliance Based on record review and interview, the facility failed to ensure 1 (R #5) of 1 (R #5-9) residents reviewed for elopement risks received the appropriate supervision to prevent or minimize the risk of elopement (an unauthorized departure of a patient from an around-the-clock care setting.) This deficient practice could likely put residents of elopement. The findings are: A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE]. B. Record review of R #5's Care Plan revealed: 1. On 05/26/23, R #5 exhibited wandering behavior that put him at risk for injury. He had diagnosis of dementia. 2. Initiated 07/25/23 and revised 09/10/23: R #5 was at risk for elopement related to impaired safety awareness, wandered in the afternoon and early evenings, knocked on doors and looked for his brother and/or the bathroom. No observed attempts at exit seeking; easily redirected. C. Record review of R #5's Elopement Risk Evaluation, dated 07/31/23, revealed R #5 was cognitively impaired, wandered aimlessly, had a history of leaving the community without informing staff, had a history of elopement while at home, and ambulated (walked) or propelled self (in a wheelchair). Score 2: No Risk. D. Record review of facility investigation report, undated, revealed on 09/06/23 at around 2:30 pm, staff saw R #5 5 minutes prior in the communal area in the dining room. A Certified Nurse Aide (CNA) returned from lunch and observed R #5 standing in the parking lot near the grass area of the neighboring apartments. The report stated the facility did not have a Wander Guard (wander management solution for senior patients and resident safety to protect those at risk of elopement) that was operational at the time of the resident's elopement. E. On 03/05/24 at 11:45 am during interview, the Regional Director of Operations (RDOC) stated there was not a Wander Guard system at the facility at one point; however, the company installed a wander guard system [09/28/23]. F. Record review of receipt provided by the facility RDOC on 03/05/24 revealed a wander guard system was installed at the facility on 09/28/23. G. Record review of R #5 physician orders (undated) revealed resident had a Wander Guard monitor to the right ankle. Staff to check the placement and function every shift. H. Record review of R #5's Elopement Risk Evaluations revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325117	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Ave Roswell, NM 88203

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Dated 11/16/23: R #5 was cognitively impaired and wandered aimlessly. R #5 ambulated and propelled self or wandered. R #5 attempted to leave the community. R #5 verbalized plan to elope from the community. Score 15: Imminent Risk 2. Dated 02/15/24: R #5 wanders aimlessly. Score 15: Imminent Risk. I. On 03/05/24 at 11:21 am during observation, R #5 was exited his room and walked fast with a slight shuffle. At 11:25 am, unknown CNA walked down the hall with R #5. R #5 wore a wander guard. J. On 03/06/24 at 9:42 am during observation, the Assistant Director of Nursing (ADON) demonstrated the functioning of the wander guard system by moving a wanderguard bracelet near the facility exit door. The door alarm beeped when the wander guard went near the door, which was heard at the nurse's stations throughout the facility. K. On 03/06/24 at 11:28 am during interview with Licensed Practical Nurse (LPN) #1, she stated R #5 was an elopement risk. She stated if a resident was an elopement risk then they have a wander guard.