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	06/07/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 2 (R #1 and #3) of 2 (R #1 and #3) residents reviewed for baseline care plans. This deficient practice could likely result in a decline in the residents' conditions due to staff not being aware of the care residents need. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's baseline care plan, dated 04/07/24, revealed only the Social Services section was completed. Sections: Nursing Services, Rehabilitative Services, Nutritional Services, and Activities were blank and incomplete. C. On 06/06/24 at 6:07 pm, during an interview with the Regional Clinical Consultant (RCC), she confirmed R #1's baseline care plan was incomplete and should not have been. D. On 06/07/24 at 9:47 am, during an interview with the Minimum Data Set Coordinator (MDSC), he confirmed R #1's base line care plan was incomplete, and staff should have completed R #1's baseline care plan upon admission into the facility. 50207 R #3: E. Record review of R #3's face sheet revealed she was admitted to the facility on [DATE]. F. Record review of R #3's baseline care plan, dated 06/02/24, revealed the sections for Nursing Services, Nutritional Services, and Activities were blank and incomplete. G. On 06/06/24 at 6:16 pm, during an interview with the Regional Nurse, she confirmed that R #3's baseline care plan was incomplete and stated it did not meet her expectations.

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: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Sunset Villa Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on record review and interview, the facility failed to update and implement a comprehensive person-centered care plan for 1 (R #2) of 1 (R #2) residents reviewed for comprehensive care plans when the facility failed to have a current plan in place. Failure to have a current comprehensive person-centered care plan in place may result in staff not understanding and implementing the needs and treatments of residents. The findings are: A. Record review of R #2's Face Sheet revealed R #2 was admitted to the facility on [DATE]. B. Record review of R #2's care plan, dated 04/24/24, revealed all items listed as canceled which indicated the resident did not have a current care plan in place. C. On 06/06/24 at 6:24 pm, during an interview with Regional Nurse she stated she did not see a current care plan for R #2. She confirmed R #2 did not have a current, updated care plan to implement due to all items listed in the care plan were canceled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Sunset Villa Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 41988

Based on record review and interview, the facility failed to prevent an accident for 2 (R #1 and #6) of 2 (R #1 and #6) residents reviewed for falls:

1. When the facility failed to ensure R #1, who was a fall hazard, was not left alone while in the restroom.

2. When therapy failed to use a gait belt for R #6.

3. When the facility failed to immediately assess R #6 following the fall to check for injuries.

These deficient practices likely resulted in R #1 and R #6 having falls with injuries that required treatment at the hospital. The findings are:

R #1:

A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses:

1. Myelodysplastic Syndrome (a group of disorders caused by blood cells that are poorly formed or do not work properly).

2. Unsteadiness on feet.

3. Repeated falls.

B. B. Record review of R #1's fall risk assessment, dated [DATE], revealed R #1's fall risk score was a 7, moderate fall risk, and required activities of daily living (ADL; fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) assistance from staff.

C. Record review of R #1 medical record did not include a care plan or any other direction to staff regarding R #1's fall risk.

D. Record review of R #1's nursing progress notes, dated [DATE], revealed R #1 had an unwitnessed fall in the bathroom trying to transfer himself off of the toilet. The resident hit his head and received a laceration to back of his head that bled. R #1 had a history of six to seven falls recently at home.

E. Record review of R #1's hospital documentation, dated [DATE], revealed the resident sustained an injury to the head. Patient presented to the Emergency Department (ED) via Emergency Medical Services (EMS) after an unwitnessed fall. Patient complained of head, shoulder, and neck pain. R #1 expired on [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Sunset Villa Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	F. Record review of R #1's nursing progress notes, dated [DATE],revealed R #1 was placed on the toilet and was alert and oriented (A&O; a way of measuring the extent of a person's awareness) at the time. The Certified Nursing Assistant (CNA) went back into the bathroom, and the resident was on the floor on his back with his head tilted toward the wall by the door. The resident was unresponsive. R #1's daughter wanted her father transferred to the emergency room (ER) for further evaluation. Upon arrival a computerized tomography scan (CT scan; uses a computer that takes data from several X-ray images of structures inside a human or animal body and converts them into pictures on a monitor) was performed, and R #1's results were a brain bleed. G. On [DATE] at 2:17 pm during an interview with R #1's Power of Attorney (POA; The authority to act for another person), she stated R #1 was left unsupervised at the facility, and he fell . The POA stated staff should not have left R #1 alone. She said R #1 fell because he was left unsupervised, and he got a brain bleed. The POA stated hospice did not want R #1 at home prior to being admitted at the facility, because he was a fall risk. She stated that was why he went to the facility in the first place. H. On [DATE] at 3:21 pm during an interview with R #1's Hospice Registered Nurse (HRN), she stated she thought the resident fell on the day he arrived at the facility, [DATE]. She stated she got to the facility at 7:35 am on [DATE]; and the staff reported to her that R #1 was assisted to the toilet, left alone on the toilet for an undisclosed period of time, and another CNA found him unresponsive on the floor. The HRN stated R #1 had a history of falls, and the facility knew that. She stated the facility staff never should leave someone who was a fall risk on the toilet alone. I. On [DATE] at 4:10 pm during an interview with R #1's daughter, she stated the facility staff left R #1 alone in the bathroom so the staff could attend to other tasks while the resident used the bathroom. She stated the facility staff said R #1 was unconscious for about four minutes. The daughter stated the facility sent R #1 to the hospital, and the hospital found a brain bleed. The daughter stated when the resident was admitted to the facility, she told the staff not to leave the resident alone, because he was a fall risk. J. On [DATE] at 4:44 pm during an interview with CNA #1, she stated they did not leave residents alone when toileting if the resident was a fall risk. She stated she would put them on the toilet and wait by the bathroom door. CNA #1 stated they were given the information on who was a fall risk at shift change, and it was also in their care plan. CNA #1 stated she was aware that R #1 was a fall risk. K. On [DATE] at 4:53 pm during an interview, CNA #2 stated residents who are considered a fall risk should not be left alone when using the toilet. CNA #2 also stated sometimes she will perform other tasks and briefly leave a resident who is a fall risk alone on the toilet to complete the task. She stated she will return right away to the resident. CNA #2 was aware R #1 was a fall risk. L. On [DATE] at 5:13 pm during an interview with Registered Nurse (RN) #1, she stated R #1 was a fall a risk. She stated her expectation was for the CNAs to stay with the resident. RN #1 stated the CNAs were trained as to who was a fall risk, and the information was also in the residents' care plans. M. On [DATE] at 5:51 pm during an interview with the Director of Nursing (DON), the DON stated staff should not leave residents who are considered a fall risk alone while using the toilet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Sunset Villa Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	N. On [DATE] at 6:05 pm during an interview with the Regional Clinical Consultant (RCC), she stated she did not know who the CNA was that found R #1 or left R #1, but R #1 should not have been left alone to use the toilet when he was considered a moderate fall risk. O. On [DATE] at 9:46 am during an interview with the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) Coordinator (MDSC), he stated R #1 was admitted into the facility because R #1 was a fall risk. The MDSC also stated staff should not leave anybody who was at risk for falls alone on the toilet, in his professional opinion as a Registered Nurse. 47031 R #6: P. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE] with the following diagnoses: 1. Cognitive communication deficit. 2. Muscle weakness. 3. Other lack of coordination. 4. Need for assistance with personal care. Q. Record review of the facility fall policy, dated ,d+[DATE], revealed the following guidelines after a resident experienced a fall: - Evaluate the resident promptly in order to identify and treat injuries. - The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. - The evaluation should include vital signs and neurological status. R. Record review of R #6's fall risk assessment, dated [DATE], revealed R #6's fall risk score was a 10, high fall risk, and required assistance (standby, walker, cane, gait belt, hands-on) from staff. S. Record review of R #6's nursing progress notes, dated [DATE], revealed R #6 fell outside during a therapy session. The Occupational Therapy Aide (OTA) witness the resident's fall. R #6 was assisted off the ground without notification to the nurse for a fall assessment, per facility protocol. The OTA assisted the resident into the building and to the dining table for lunch. R #6 requested Tylenol for general discomfort, and staff administered a dose to the resident T. Record review of nurses note, dated [DATE], the resident was sent to the ED because of emesis (the forceful ejection of some or all of the contents of the stomach through mouth) with headache. R#6 was assessed and given medication at the ED and was sent back to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER: Sunset Villa Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 - Actual harm Residents Affected - Few	U. On [DATE] at 9:30 am during interview with Regional Corporate Therapy Consultant (RCTC), she stated staff did not follow facility protocol and use a gait belt with the resident. She stated it was expected staff would follow protocol. V. On [DATE] at 10:00 am during an interview with the OTA, she stated R #6 had a fall, and she did not follow facility protocol. The OTA stated she did not put a gait belt on the resident. She stated R #6's strength, balance, and everything was getting better; and she did not think about the gait belt. She stated she knew better and usually used one. The OTA also stated R #6 did not hit her head when she fell so she assisted R #6 up without having her assessed by a nurse. W. On [DATE] at 10:25 am during an interview with the MDS Coordinator, he stated staff should follow facility protocol for all residents. X. On [DATE] at 5:39 pm during interview with LPN #1, she stated she was not made aware of R #6's fall until after lunch. LPN #1 stated the OTA should have called a nurse to assess the resident after the fall, but the OTA did not. LPN #1 stated she assessed the resident when she gave the resident Tylenol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 50207 Based on observation and interview, the facility failed to ensure all medication carts were locked while not in use. This deficient practice had the potential to affect all 19 people residing in rooms 100-111 as identified by the resident census provided by the Administrator on 06/06/24 by allowing unauthorized persons access to their medications and personal health information. The findings are: A. On 06/06/24 at 10:52 am, during a random observation of the facility, the medication cart located near the nurse's station was unlocked, and staff were not in the area. Further observation revealed R #3, R #4, and R #5 were present in the area. B. On 06/06/24 at 10:57 am, during an interview with the Director of Nursing (DON), he confirmed the medication cart was unlocked, and facility employees were not in the area. The DON stated an unattended, unlocked medication cart did not meet his expectations, because it should have been left locked if a nurse was not present and working out of it.