STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32E083	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Care Center LLC	1629 Bowe Lane SW Albuquerque, NM 87105

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50752 Based on record review and interview, the facility failed to notify the resident's physician when a resident did not eat for an extended period of time and loss significant weight for 1 (R #1) of 1 (R #1) resident. If the facility is not notifying the physician then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the proper care. The findings are: A. Record review of R #1's face sheet, dated 11/19/24, revealed R #1 was admitted to the facility 06/14/19. B. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 07/01/24, revealed R #1 had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of seven (7), severely impaired. C. Record review of R #1's physician orders, dated September 2024, revealed the following: a. Diagnoses included: - Alzheimer's disease (a disease which causes irreversible changes in memory, thinking, and behavior), - Type 2 diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar), - Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), - Encephalopathy (a degenerative brain disease that alters brain function or structure.) b. Diet: Regular. D. Record Review of R #1's meal intake revealed the following: (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 09/01/24, R #1 refused breakfast and dinner. b. On 09/04/24, R #1 refused breakfast. c. On 09/05/24, R #1 refused breakfast, lunch, and dinner. d. On 09/06/24, R #1 refused breakfast and lunch. e. On 09/07/24, R #1 refused breakfast, lunch, and dinner. f. On 09/08/24, R #1 refused breakfast, lunch, and dinner. g. On 09/09/24, R #1 refused breakfast and lunch. h. On 09/10/24, R #1 refused breakfast and lunch. i. On 09/11/24, R #1 refused breakfast and lunch. j. On 09/12/24, R #1 refused breakfast and lunch. k. On 09/13/24, R #1 refused breakfast and lunch. l. On 09/14/24, R #1 refused lunch and dinner. m. On 09/15/24, R #1 refused breakfast and dinner. n. On 09/16/24, R #1 refused breakfast, lunch, and dinner. o. On 09/17/24, R #1 refused breakfast, lunch, and dinner. p. On 09/17/24, R #1 refused lunch and dinner. E. Record Review of R #1's of monthly weights revealed the following: a. In March 2024, the resident weighed 207.4 pounds (lbs.) b. In June 2024, the resident weighed 199.4 lbs. c. In August 2024, the resident weighed 200.6 lbs. d. In September 2024, the residents weighed 186.4 lbs. e. The resident experienced a 7.8 percent (%) weight loss in one month (August to September 2024) and a 10.13% weight loss in six months (March to September 2024.) (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #1's New Mexico Medical Orders for Scope of Treatment (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form, dated 01/17/24 and signed by the PA and the resident, revealed the resident was full code but did not want artificial nutrition. G. Record review of R #1's Physician's Progress Notes revealed the following: a. Date of service was 09/11/24. Signed by the Physician's Assistant (PA) on 09/16/24. admitted [DATE], with a readmission from the hospital on 07/23/24. The resident recently had pneumonia, poor intake, and concentrated urine. Staff reported possible small coffee ground emesis (vomit) with some hypoxemia (low levels of oxygen in the blood). The resident was provided one liter normal saline (NS) secondary to poor intake. Resident continued to be resistant to her oral medications and care. Review of body systems (ROS) showed decline. Resident allowed staff to feed her highly sweetened foods and fluids. The resident's weight was documented as 186 lbs with a note to re-weigh the resident. The resident was irritable, oriented to person and situation, had limited short-term recall and poor judgment. The record did not address the resident's weight loss over the one month and six month period. b. Date of service was 09/18/24. Signed by the PA on 09/26/24. Discharge Summary. The resident became hypoxic (low levels of oxygen in the blood) with some apnea (temporary cessation of breathing.) Since returning from the hospital, the resident would only drink concentrated sweets such as malts, no pureed food. The resident had been resistant to all care. No labored breathing at visit with use then reporting changes of apnea. discharged to the hospital, stabilized by Emergency Medical Technicians (EMT.) H. Record review of R #1's nurses notes revealed the following: a. Dated 09/16/24, resident was alert and verbal, usually answered with one or two words. R #1 required assistance with all meals. b. Dated 09/18/24, resident had apnea attacks. R #1 was unresponsive to verbal stimuli with rapid shallow breathing. c. Dated 09/18/24, staff notified the Assistant Director of Nursing (ADON) of the resident's condition. R #1 was sent to the hospital. d. The record did not contain documentation to show staff notified the resident's physician (the Medical Director) regarding the resident's refusal to eat, significant weight loss, and discharge to the hospital. I. On 02/14/25 at 11:00 am, during an interview with Hospital Caseworker (HC), she stated the resident was dehydrated and appeared malnourished when she was admitted to the hospital on 09/18/24. The HC stated the resident was admitted to the hospital on 09/19/24 and passed away 30 days later while at the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 02/14/25 at 11:42 am, during an interview, the ADON stated R #1 would eat only when she wanted to eat. The ADON stated R #1 often cursed, hit, and spat at the staff when they assisted the resident with eating. The ADON stated they could not force residents to eat, but they could encourage them. The ADON stated R #1 refused to get a gastrostomy tube (G-tube; a tube surgically inserted through the abdomen into the stomach and used to provide fluids, nourishment, and medications). The ADON stated they did not send the resident to the hospital for failure to eat. She stated she did not believe the hospital would intervene, because hospitals and nursing homes often have differing perspectives on care. K. On 2/27/25 at 11:55 am, during an interview, the Medical Director (MD) stated he worked at the facility since June or July of 2024. He stated he did not have the opportunity to see all the residents, but his PA saw the residents on a regular basis. The MD stated the PA saw R #1 in September 2024, but she did not notify him of the resident's failure to eat or significant weight loss. The MD stated staff did not notify him that R #1 was not eating and lost significant weight. He stated it was expected for staff and the PA to notify him immediately if a resident did not eat or if a resident lost significant weight. He stated the facility failed to keep him informed of residents' conditions on previous occasions and he brought this to their attention. The MD stated he would have referred to the resident's advanced directives (MOST) to take into consideration the resident's wishes, but even if the resident did not want artificial nutrition, he could have made changes to the resident's orders and adjustments to the resident's diet if he had known. The MD stated if the resident received shakes or super foods (fortified foods) then that information should be reflected in the resident's orders and documented in the resident's medical record. L. On 02/27/25 at 12:22 PM, during an interview with the Physician Assistant, she stated she was not aware the resident refused to eat for two weeks. She stated she was aware the resident lost weight. The PA stated she did not notify the MD regarding the resident's weight loss, because she felt the resident's weight loss was warranted due to the resident's obesity. The PA stated she deferred to the facility's Registered Dietician (RD) since the RD had its own standards. She stated if she had been concerned about the resident's weight loss, then she would have prescribed liquid protein for the resident to consume. The PA stated she did not see the resident before R #1 left the facility, and she did not feel the need to contact the MD for any changes in the resident's care.