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	09/10/2025

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 - 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** Based on observations, record reviews and interviews, staff failed to notify the physician and Director of Nursing (DON) of changes in a resident's eye for 1 (R #1) of 1 (R #1) residents. This deficient practice could result in the resident not receiving a medical assessment or treatment, which could result in a worsening of symptoms. The findings are: A. Record review of R #1's face sheet revealed the following: -The resident was admitted to the facility on [DATE]. -The resident had a diagnosis of glaucoma (a group of eye conditions that can cause blindness). -The resident had a diagnosis of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). -The resident had a diagnosis of cataract (a cloudy area in the normally clear lens of the eye). B. Record review of R #1's Physician Orders, dated 07/24/24, revealed the following: -Staff to complete resident body check (a visual observation during personal care) each shower day, dated 07/24/24. -Refer to eye care providers as needed, dated 07/24/24. C. Record review of R #1's Care Plan, dated May 2025, revealed the resident had a diagnosis of dementia. D. On 09/10/25 at 8:27 AM, observation revealed R #1 sat in a geriatric chair (a specialized reclining chair with safety straps used to support residents who cannot sit safely in a regular chair) in the common area. Further observation revealed the resident's left eye was red and swollen, with mucus drainage present on the eyelid and cheek. The resident rubbed their left eye. Staff did not provide assistance or perform eye care. E. On 09/10/25 at, 12:10 PM, observation revealed R #1's left eye was closed shut and had dried fluid/mucous around the closed eyelid. (continued on next page)

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 - Few	F. Record review of R #1's medical records revealed the following: - Staff did not document the resident's eye redness, fluid drainage, or swelling. - Staff did not document they notified the physician of the resident's eye condition. G. On 09/10/25 at 1:25 PM, during an interview, the Registered Nurse (RN) #1 stated R#1's left eye was closed with redness and fluid/mucous on 09/10/25. RN #1 stated she wiped the resident's eye with a warm washcloth but did not document the resident's eye condition in the progress notes, notify the Director of Nursing (DON), or contact the physician. H. On 09/10/25 at, 1:28 PM, during an interview, the DON stated it was her expectation for the RNs to report any resident changes to her and the physician. She stated staff did not report R #1's eye changes to her for further assessment and provider notification. I. On 09/10/25 at 2:30 PM, during an interview, the Administrator stated RN #1 should have reported the change in the resident's eye condition to the DON. She stated it was her expectation for staff to communicate any change in the residents. The Administrator stated if staff did not communicate a resident's eye change, then the resident may have adverse reaction if care was not provided.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to:- Ensure a medication cart located on the East Hall was inaccessible to unauthorized individuals for 1 (medication cart #1) of 3 (medication carts #1, #2, and #3) medication carts. - Pick up and dispose of a dropped medication for 1 (R #3) of 1 (R #3) residents. If the facility fails to ensure medication is secured against unauthorized access, then residents are at risk of adverse drug reactions, medication errors, overdose, or death. The findings are: Unattended Medication [NAME]. Record review of the facility's Medication Storage Policy, dated 12/11/24, revealed all medication carts must remain locked and secured when not in use. B. On 09/10/25 at 8:24 a.m., during an interview, Registered Nurse (RN) #1 stated the medication cart must remain locked. She stated leaving the cart unlocked could allow a resident to access medications not prescribed to them, which could lead to overdose. C. On 09/10/25 at 8:51 AM and 11:30 AM, observation revealed the East Hall medication cart was unlocked and unattended by staff. Further observation revealed the medication cart contained antidepressants, controlled substances, resident routine daily medications, and insulin injectable pens. D. On 09/10/25 at 2:15 PM, during an interview, the Director of Nursing (DON) stated it was her expectation for all medication carts to remain locked and secured. The DON stated it was the floor nurse's responsibility to ensure medication carts remained locked. Dropped [NAME]. On 09/10/25 at 12:15 p.m., observation revealed a half, yellow pill located on the floor under the East Hall medication cart. Further observation revealed a resident ambulated near the medication cart. F. On 09/10/25 at 1:14 p.m., during an interview, RN #1 stated she dropped the half yellow pill at 9:00 a.m. She stated she did not pick it up, because she was busy. She stated staff were expected to document a dropped medication on the resident's Medication Administration Record (MAR) and in the resident's progress notes. She stated she did not document the dropped medication. RN #1 identified the dropped pill as R #3's sertraline (Zoloft, an antidepressant medication). G. On 09/10/25 at 2:15 PM, during an interview, the Director of Nursing (DON) stated staff must pick up and dispose of dropped medication immediately in a Sharps container and document the incident on the resident's MAR as not administered. The DON stated it was the floor nurse's responsibility to ensure dropped medications were immediately addressed. She stated there was always a chance a resident could pick up the medication and ingest it. The DON stated the dropped medication belonged to R #3.