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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Healthcare	1515 South Sunset Avenue 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to keep residents free from abuse for 1 (R #1) of 5 (R #1, R #2, R #3, R #4, and R #5) residents reviewed for abuse when Certified Nurse Aide (CNA) #1 was verbally abusive to R #1. This deficient practice led to R #1 feeling embarrassed. The findings are: A. Record review of the facility's Initial Incident Report dated 10/06/25 revealed that on 10/03/25 CNA #1 yanked (pulled) R #1 by her left arm while assisting her into a sitting position and made fun of her financial situation by telling her the driver was going to take her to another facility because she couldn't afford her bills.B. On 11/20/25 at 1:15 pm, during an interview with R #, she stated she does not feel like CNA #1 meant to hurt her, but she does not like to be rushed, and he was rushing her. R #1 stated he made her feel embarrassed because he was laughing at her financial situation by telling her the driver was going to take her to another facility since she couldn't pay her bills.C. Record review of CNA #1's training file revealed CNA #1 received training on abuse, neglect, and exploitation and training on resident rights on 07/04/25.D. Record review of CNA #1's termination form dated 10/06/25 revealed that CNA #1's employment at the facility was terminated due to abuse.E. On 11/21/25 at 9:20 am during an interview with the Administrator (ADM), she confirmed CNA #1's employment with the facility was terminated on 10/06/25 due to abuse.

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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report allegations of abuse and neglect to the State Agency within twenty-four hours for 3 (R #1, R #2, and R #3) of 5 (R #1, R #2, R #3, R #4, and R #6) residents reviewed for abuse and neglect. If the facility fails to report allegations of abuse and neglect to the State Agency, then the State Agency is unable to ensure residents are free from abuse and neglect. The findings are: A. Record review of the facility's Initial Incident Report dated 10/06/25 revealed that on 10/03/25 CNA #1 yanked (pulled) R #1 by her left arm while assisting her into a sitting position and made fun of her financial situation by telling her the driver was going to take her to another facility because she couldn't afford her bills. B. Record review of the facility's Initial Incident Report dated 09/30/25, received by the State Agency on 10/01/25, revealed the following:1. An allegation of neglect where CNA #2 assisted R #2 to bed with a dirty (urine and bowel movement) adult brief on and did not assist with personal care that occurred on 09/30/25.2. An allegation of neglect where CNA #2 said R #3 refused his meal, but she never offered it to him on 09/30/25.C. On 11/21/25 at 9:20 am during an interview with the Administrator (ADM), she confirmed that CNA #2 last worked at the facility on 09/28/25, indicating the date of incident was 09/28/25, not 09/30/25. The ADM confirmed both Initial Incident Reports (dated 10/06/25 and 09/30/25) were not submitted to the State Agency within the required timeframe.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to report the results of all investigations to the State Survey Agency within five working days of an incident for 3 (R #1, R #5, and R #6) of 6 (R #1, R #2, R #3, R #4, R #5, and R #6) residents reviewed for abuse or neglect. If the facility is not submitting the summary of the facility's investigation to the State Survey Agency, then the State Survey Agency is unable to appropriately triage (review) the allegation for further investigation. The findings are:A. Record review of the facility's Initial Incident Report dated 10/06/25 revealed an alleged incident of abuse where Certified Nurse Aide (CNA) yanked (pulled) R #1 by her left arm while assisting her into a sitting position which occurred on 10/03/25.B. Record review of the facility's investigation summary, no date, revealed the summary report was submitted to the State Survey Agency on 10/13/25 (six working days after the incident).C. Record review of the facility's Initial Incident Report dated 10/02/25 revealed a resident-to-resident altercation where R #5 physically assaulted R #6. D. On 11/21/25 at 9:20 am during an interview with the Administrator (ADM), she confirmed the following:1. The facility's investigation summary for the incident regarding R #1 was not submitted within five working days.2. The facility failed to submit the investigation summary for the altercation between R #5 and R #6.