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	04/23/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 2 (R #3 and R #37) of 5 (R #1, R #3, R #15, R #37, and R #48) residents reviewed for unnecessary medications, when staff failed to:1. Ensure that as needed psychotropic medications are limited to only 14 days or indicate the duration of the as needed (PRN) order for R #3 and R #37.2. Ensure monitoring for possible side effects of an anti-psychotic medication for the duration of the order for R #3.These deficient practices could likely lead to adverse drug effects and poor patient outcomes. The findings are:R #3 A. Record review of R #3's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Anxiety (feelings of fear or apprehension), 2. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), 3. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly), 4. Cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain). B. Record review of physician orders dated 02/17/26 revealed an order for hydroxyzine 50 milligrams (mg) every eight hours as needed for anxiety. No stop date listed. C. On 04/23/26 at 12:25 pm, during an interview with the Director of Nursing (DON), she confirmed that the order for the hydroxyzine did not have a stop date and it should. R #37 D. Record review of R #37's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Depression, 2. Anxiety, 3. Cerebral infarction, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 5. Impulse disorder (type of mental health condition where a person has a strong, uncontrollable urge or impulse to do something that is harmful, dangerous, or against the law). E. Record review of physician orders dated 12/24/26 revealed an order for Ativan one mg every four hours as needed for agitation and restlessness. F. On 04/23/26 at 12:25 pm, during an interview, the DON confirmed that the Ativan order did not contain a stop date. She stated the medication should have had a 14ˆday renewal date or should have been discontinued but it was not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment accurately reflected residents' clinical status for 2 (R #2 and R #31) of 4 (R #2, R #4, R #9, and R #31) residents reviewed for assessments.ˆThis deficient practice could likely result in the residents' needs not being met. The findings are: R #2 A. Record review of R #2's admission Record revealed R #2 was admitted to the facility on [DATE] with the following diagnoses: 1. Type two diabetes mellitus (DM2, a metabolic disorder leading to elevated blood glucose), 2. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety), 3. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). B. Record review of R #2's physician order dated 12/25/25 revealed amitriptyline (antidepressant medication) 100 milligram (mg) to be given daily at bedtime for depressive symptoms. C. Record review of R #2's MDS assessment dated [DATE] revealed 1. R #2 does not take antidepressant medications. 2. R #2 received schedule pain medications. D. On 04/23/26 at 11:57 am during an interview with the MDS coordinator, he confirmed: 1. R #2 does take antidepressant medications, 2. R #2 has not taken any pain medications, 3. The MDS assessment for R #2 is inaccurate. R #31 E. Record review of R #31's admission Record revealed she was originally admitted to the facility on [DATE] with the following diagnoses: 1. Spondylolysis (natural wear and tear of the cushiony discs in the spine over time with age), 2. Low Back Pain, 3. Hypertension (HTN; high blood pressure), 4. Anxiety disorder (feelings of fear or apprehension). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of physician orders dated 01/05/26 revealed an order for tramadol (an opioid pain medication) for low back pain. G. Record review of MDS assessment dated [DATE] revealed R #31 does not take opioid medication. H. On 04/23/26 at 11:55 am during an interview with MDS coordinator, he confirmed R #31's MDS assessment is not accurate because it does not indicate R #31's use of an opioid medication and it should.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen (plan to manage a person's medication) was free from unnecessary drugs by ensuring residents receiving diuretic therapy were appropriately monitored for edema for 1 (R #48) of 5 (R #3, R #5, R #15, R #43, and R #48) residents reviewed for unnecessary medication. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are:A. Record review of R #48's admission Record revealed he was admitted to the facility on [DATE] with diagnoses of:1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),2. Long-term use of anticoagulants (blood thinner),3. Edema (swelling caused by excess fluid).B. On 04/20/26 at 11:00 am an observation and interview of R #48 revealed him socializing in the dining room with other residents. Both of his lower legs had visible redness and swelling. R #48 stated that he has swelling daily and does take medication to help it.C. Record review of R #48's Physician Orders revealed no monitoring in place for edema.D. Record review of R #48's Pharmacy Medication Review (MRR) dated 01/07/26, revealed a new recommendation to monitor resident for increased edema and notify physician if present.E. On 04/26/26 at 12:54 pm during an interview with the Director or Nursing (DON) she confirmed R #48's care plan was not updated to reveal management of his edema while on a diuretic and it should have been.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #48) of 5 (R #3, R #5, R #15, R #43, and R #48) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, they are not able to make informed decisions regarding residents' care. The findings are: A. Record review of R #48's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Anxiety (feelings of fear or apprehension),2. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),3. Cardiac arrhythmia (irregular heartbeat).B. Record review of R #48's physician's orders revealed the following:1. An order dated 07/17/25 for Lorazepam (anti-anxiety medication), 0.5 milligrams (mg) to be given by mouth two times a day for anxiety.2. An order dated 01/08/26 for Zoloft (anti-anxiety/anti-depressant medication), 25 mg to be given by mouth one time a day for anxiety.C. Record review of R #48's electronic health record (EHR) revealed no consent was obtained before the Lorazepam and Zoloft medications were started.D. On 04/23/26 at 1:00 pm, during an interview with the Director of Nursing (DON), she confirmed staff did not obtain the consent forms prior to starting the Lorazepam and Zoloft. The DON stated this does not meet her expectations because the consent forms are to be obtained prior to the start of the medications and these were not.

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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** Based on observation, record review and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 2 (R #5 and R #48) of 5 (R #3, R #5, R #15, R #43 and R #48) residents reviewed for care plans when staff failed to develop: 1. A care plan with goals and interventions for R #5's diagnosis of type 2 diabetes mellitus (DM2, a condition results from insufficient production of insulin, causing high blood sugar). 2. A care plan with goals and interventions for R #48's:-Use of an anticoagulant (medication that prevents blood from clotting) medication,-Diagnosis of edema (swelling caused by excess fluid). This deficient practice could likely result in proper care not being provided to residents.The findings are:R #5A. Record review of R #5's admission Record revealed he was admitted to the facility on [DATE] with diagnoses of Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar).B. Record review of R #5's physician orders revealed the following:1. An order dated 04/13/26 for 20 units of Lantus (long-lasting insulin used to lower blood sugar levels) to be administered in the morning.2. An order dated 11/15/25 for Insulin Aspart (short-acting insulin used to lower blood sugar level) to be administered before meals and at bedtime.3. An order dated 12/26/25 for ten units of Insulin Glargine (long-acting insulin) to be administered at bedtime.C. Record review of R #5's care plan last revised on 04/29/26, revealed no care plan for diabetes mellitus.D. On 04/22/26 at 9:00 am during an interview with Registered Nurse (RN) #1 she confirmed R #5 has diabetes mellitus.E. On 04/26/26 at 12:54 pm during an interview with the Director of Nursing (DON) she confirmed R #5 has a diagnosis of diabetes mellitus. The DON confirmed the facility should have developed a care plan to address R #5's diabetes mellitus but failed to do so. R #48F. Record review of R #48's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Type 2 diabetes mellitus,2. Long-term use of anticoagulant medications.3. EdemaG. On 04/20/26 at 11:00 am, an interview and observation with R #48 in his dining room revealed both of his lower legs had visible redness and swelling. R #48 stated that he has redness and swelling daily and confirmed he takes a diuretic medication (a medication that helps reduce swelling through removing salt and water through urine).H. Record review of R #48's physician orders revealed an order for furosemide, 20 milligrams (mg) to be given in the morning for edema.I. On 04/26/26 at 12:54 pm during an interview with the DON, she confirmed R #48 does have edema. The DON confirmed the facility should have developed a care plan to address R #48's use of anticoagulant medication and his edema and failed to do so.

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on record review and interview, the facility failed to provide quality of care when staff failed to monitor 1 (R #48) of 5 (R #3, R #5, R #15, R #43, and R #48) residents reviewed for edema. These deficient practices could likely result in residents not getting the treatment needed and/or potentially worsening conditions. The findings are: A. Record review of R #48's admission Record revealed he was admitted to the facility on [DATE] with diagnoses of:1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),2. Long-term use of anticoagulants (blood thinner),3. Edema (swelling caused by excess fluid).B. Record review of R #48's Quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment dated [DATE], revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact.2. R #48 is on a diuretic (a medication that helps reduce swelling through removing salt and water through urine).C. Record review of R #48's Nursing Summary Report dated 01/07/26, revealed a new recommendation to monitor #48 for increased edema and to notify the physician if present.D. On 04/20/26 at 11:00 am, an interview and observation with R #48 in the dining room revealed both of his lower legs had visible redness and swelling. R #48 stated that he has redness and swelling daily and confirmed he takes a diuretic medication.E. Record review of R #48's physician orders revealed the following:1. An order for furosemide, 20 milligrams (mg) to be given in the morning for edema,2. No monitoring in place for edema.F. On 04/26/26 at 12:54 pm during an interview with the Director of Nursing (DON), she confirmed R #48 does have edema. The DON confirmed the facility should have been monitoring R #48's edema and failed to do so.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure the call light was in working order for 1 (R #4) of 3 (R #2, R #4, and R #8) residents reviewed during random observation of the facility. If the facility is not ensuring a working call light system, then residents and staff are unable to request immediate assistance when needed. The findings are:A. On 04/20/26 at 9:29 am, during an observation and interview with R #4, she stated she needed help and pushed her call light. She stated nobody was coming. There was no light outside of R #4's room.B. On 04/20/26 at 9:34 am, during an interview with the Director of Nursing (DON), she confirmed the call light was not working. The DON stated the light bulb must have burnt out.