STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325040	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Sands Healthcare	5715 North Lovington Highway Hobbs, NM 88240

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 - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to keep a resident free from abuse for 1(R #4) of 8(R #1-8) residents reviewed for abuse when Nurse Aide in Training (NAIT) #2 was verbally and physically abusive to R #4 when providing care. This deficient practice likely resulted (based upon the reasonable person standard) in R #4 experiencing emotional distress and trauma. The findings are:A. Record review of R #4's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),2. Anxiety (feelings of fear or apprehension) disorder,3. Legal blindness (inability to see),4. Cerebrovascular disease (refers to a group of disorders affecting blood flow to the brain, leading to conditions such as stroke, aneurysms, and vascular malformations).B. Record review of R #4's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 08/22/25, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 1 (severe impairment).C. Record review of R #4's care plan dated 07/31/25 revealed the following:1. R #4 is dependent on staff for meeting his emotional, intellectual, physical, and social needs.2. R #4 has a self-care deficit related to activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating).D. Record review of the facility's Reportable Incident form dated 09/05/25 revealed NAIT #2 was popping (to strike or knock sharply) R #4 on the mouth, told R #4 to hush and covered R #4's mouth with her hand.E. Record review of R #4's progress note dated 08/29/25 revealed the following:1. CNA #1 reported to LPN #1 on 08/22/25 that NAIT #2 slapped R #4 and covered his mouth. 2. CNA #1 provided an audio recording of the incident.F. Record review of CNA #1's written witness statement dated 08/28/25 revealed NAIT #2 became agitated with R #4 and slapped R #4 on the mouth and told him to hush. NAIT #2 aggressively placed R #4 into the sit and stand machine (an adaptive device used to aid a person from a sitting to standing position) and when R #4 continued to speak, NAIT #2 put her hand over R #4's mouth. After putting R #4 to bed, NAIT #2 threw R #4's feet up and told him to go to sleep. R #4 then stated that he needed to urinate, and NAIT #2 told him to urinate in his brief.G. On 10/21/25 multiple attempts were made to reach CNA #1 via phone calls (8:50 am, 8:51 am, and 12:44 pm) and a text message (at 12:46 pm). There was no reply or returned call from CNA #1.H. Record review of NAIT #2's written witness statement dated 08/29/25 revealed the following:1. NAIT #2 admitted to telling R #4 to hush while preparing to use the sit and stand machine.2. NAIT #2 denied ever hitting R #4 and admitted to playfully tapping him while he was talking.I. Record review of Licensed Practical Nurse (LPN) 1's written witness statement dated 09/08/25 revealed on 08/29/25, CNA #1 witnessed and reported to her that NAIT #2 slapped R #4, covered R #4's mouth, and was yelling at R #4 to shut up. CNA #1 provided an audio recording of this incident.J. Record review of the audio recording dated 08/22/25, provided by Administrator on 10/14/25 revealed CNA #1 recorded NAIT #2 verbally abusing R #4 by:1. Yelling at R #4 to hush and shut up,2. Mocking R #4 by repeating the same words he was saying,3. Saying .I want to thump the shit of him sometimes,4. Threatening R #4 by telling him that they are going to drop him because he doesn't know how to be quiet,5. Yelling instructions such as let go and hold on to R #4,6. Telling R #4 to urinate in his brief after R #4 said he needed to urinate.K. Record review of the NAIT #2's timecard revealed NAIT #2 worked at the facility 08/24/25, 08/27/25, and 08/28/25.L. On 10/14/25 at 3:25 pm, during an interview with R #4, he stated he was unable to recall the incident.M. Record Review of R #4's Trauma Informed assessment dated [DATE] indicated that R #4 had past childhood trauma in elementary school. R #4 indicated he still feels scared, helpless and horrified regarding this past trauma and experiences nightmares. R #4 also indicated he will go out of his way to forget past trauma. N. Record Review of R #4's Safe Survey (tool used to help identify residents' concerns with staff) dated 08/29/25 revealed R #4 is afraid of a staff member at the facility but unsure of their name.O. On 10/14/25 at 4:31 pm, during an interview with the Director of Nursing (DON), she stated once the facility was made aware of an allegation of abuse on 08/29/25 an investigation was initiated, and NAIT #2 was immediately placed on suspension. The DON confirmed that following the substantiation of the facility's investigation of abuse and NAIT#2's employment was terminated on 09/10/25. Based on interview and record review, Immediate Jeopardy (IJ) was identified, and the Administrator and Director of Nursing were notified in person on 11/17/25 at 6:15 pm.The facility took corrective action by providing an acceptable Plan of Removal (POR) on 11/18/25 at 1:55 pm which verified implementation of the plan of

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 an allegation of abuse for 1(R #4) of 8(R #1-8) residents reviewed for abuse, when staff waited 7 days to report witnessed staff to resident abuse. If the staff fail to report allegations of abuse to the facility administration, then corrective measured may not be acted on and the facility would be unable to assure residents are free from abuse. The findings are:Cross reference findings for F600A. Record review of R #4's complaint report dated 08/29/25 revealed on 08/22/25 an alleged incident of abuse had occurred as follows:- Certified Nurse Aide (CNA) #1 had witnessed NAIT (Nurse Aide in Training) #2 cover R #4's mouth with hand, tap his mouth with her hand, and told R #4 to shut up.-The incident was reported to the management team on 08/29/25. NAIT #2 continued to work until management was notified of incident. NAIT #2 remained in the unit and the residents in the unit were at risk for further abuse by the accused NAIT #2.B. Record review of facility timesheets identified that NAIT #1 worked at the facility on 08/22/25, 08/24/25, 08/27/25 and 08/28/25.C. On 10/14/25 at 2:40 pm during interview with Registered Nurse RN) #1 confirmed that CNA #1 told her about the incident on 08/22/25 and CNA #1 reported to RN #1 that she [CNA #1] didn't know what to do about it [reason for not reporting sooner.] RN #1 immediately reported what CNA #1 told her to the Unit Manager/LPN #2 on 08/29/25. D. On 10/14/25 at 2:42 PM during interview with the Director of Nursing (DON), she confirmed the facility failed to report the allegation of abuse within the required two-hour timeframe because she did not become aware of the allegation until 08/29/25. DON confirmed that the initial report was submitted to the State Agency on 08/29/25, seven days after the incident. Based on interview and record review, Immediate Jeopardy (IJ) was identified, and the Administrator and Director of Nursing were notified in person on 11/17/25 at 6:15 pm.The facility took corrective action by providing an acceptable Plan of Removal (POR) on 11/18/25 at 1:55 pm which verified implementation of the plan of removal as of 09/03/25. Immediate Jeopardy was removed on 09/03/25, which constituted Past Non-Compliance IJ. Plan of removal:R #4 was immediately assessed by using a Trauma Informed Assessment. No immediate concerns noted. Completed 08/29/25.Tele-visit with Psych provider, agreed with Trauma Informed Assessment for R #4, no immediate trauma and will continue psych caseload. Completed 08/29/25.Safe survey for all facility residents were immediately initiated with no immediate concerns verbalized. Residents verbalized desire to continue living in facility and feel safe. Completed 09/03/25 and then again on 11/18/25.Referral for additional spiritual services for support within the community for R #4 via hospice team. Completed 08/29/25.R #4's Care Plan updated for trauma-informed care.Record review of R #4 records on 10/14/25 verified the above records.All staff were re-educated on 08/29/25 and 08/30/25.1. Abuse and neglect definition, signs and symptoms of abuse and reporting and when to report.2. Zero-tolerance expectation.3. Resident rights.4. Mandatory reporting within 2 hours.Record review of Training sign-in sheets on 10/14/25 verified staff training was conducted for all facility staff on 08/29/25 and then again on 09/30/25.Interviews with NAIT #1, CNA #1-3 on 10/14/25 verified that they received the above training.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure a Nurse Aide in Training (NAIT) completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) or a Competency Evaluation Program (CEP) within four months of being employed at the facility. This deficient practice is likely to affect all 108 residents residing at the facility by allowing untrained staff to provide direct care to residents. The findings are:A. Record review of NAIT #1's personnel record reviewed the following:1. NAIT #2's hire date was 11/15/24.2. NAIT #2 became a Nurse Aid in training on 02/16/25.3. NAIT #2's date of Certified Nurse Aide certification was 8/26/25.B. Record review of NAIT #2's timesheet revealed NAIT #2 worked a total of 99 shifts between 02/16/25 and 08/26/25.C. On 10/14/25 at 5:29 pm, during an interview with the Human Resources Director (HRD), she confirmed NAIT #2 received her certification late and continued to work shifts during that time. She stated her expectation is for all nurse aids to become certified within four months.