| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325040 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Sands Healthcare | 5715 North Lovington Highway<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**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 3 (R #2, R #6, and R #9) of 5 (R #2, R #5, R #6, R #9, and R #31) residents reviewed for unnecessary medications, when staff failed to:1. Ensure psychotropic medications were necessary to treat a specific condition as diagnosed and documented in the clinical record for R #2.2. Ensure as needed psychotropic medications are limited to only 14 days or indicate the duration of the as needed (PRN) order for R #9.These deficient practices could likely lead to adverse drug effects and poor patient outcomes. The findings are:R #2<br><br>A. Record review of R #2's admission Record revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Unspecified mood disorder (mental health condition that is characterized by a persistent feeling of sadness, hopelessness, and loss of interest or pleasure in activities that were once enjoyable),<br><br>2. Generalized anxiety disorder (an overall feeling of fear or apprehension),<br><br>3. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),<br><br>4. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety),<br><br>5. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),<br><br>B. Record review of R #2's physician's order dated 07/28/24 for divalproex sodium, five-hundred milligrams (mg) to be given by mouth two times a day for mood stabilizer.<br><br>C. Record review of R #2's physician's order dated 05/02/25 for quetiapine fumarate, one-hundred mg to be given by mouth two times a day for mood disorder.<br><br>D. On 03/12/26 at 10:30 am, during an interview with the Director of Nursing (DON), she confirmed the following:<br><br>1. R #2's indicated use of divalproex sodium is mood stabilizer,<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325040 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2026 |
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| NAME OF PROVIDER OR SUPPLIER White Sands Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 5715 North Lovington Highway Hobbs, NM 88240 | |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. R #2 does not have a diagnosis for mood stabilizer,<br><br>3. R #2's indicated use of quetiapine fumarate is mood disorder,<br><br>4. R #2 does not have a diagnosis for mood disorder, nor does mood stabilizer qualify as a specific condition for prescribing quetiapine fumarate.<br><br>5. Medications should be documented to treat specific conditions as diagnosed and these were not.<br><br>R #6<br><br>E. Record review of R #6's admission Record revealed R #6 was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Peripheral vascular disease (PVD; poor circulation),<br><br>2. Extramedullary plasmacytoma not having achieved remission (a rare type of plasma (liquid part of the blood) cell neoplasm (cancer) that occurs outside the bone marrow (a soft fatty substance in the cavities of bones, in which blood cells are produced).<br><br>F. Record review of R #6's physician's order dated 12/11/25 for aspirin oral chewable tablet, eighty-one mg to be given by mouth once a day for prophylactic measures.<br><br>G. Record review of R #6's physician's order dated 12/12/25 for Bactrim DS (an anti-infective) oral tablet 800-160 mg (Sulfamethoxazole-Trimethoprim) to be given once a day for chemotherapy.<br><br>H. On 03/12/26 at 10:30 am, during an interview with the DON, she confirmed the following:<br><br>1. R #6's indicated use of aspirin is prophylactic measures,<br><br>2. R #6 does not have a diagnosis for prophylactic measures, nor does prophylactic measure stand as a diagnosis,<br><br>3. R #6's indicated us of Bactrim DS is chemotherapy,<br><br>4. R #6 does not have a diagnosis for chemotherapy.<br><br>5. Medications should be documented to treat specific conditions as diagnosed and these were not.<br><br>R #9<br><br>I. Record review of R #9's admission Record revealed R #9 was admitted to the facility with the following diagnoses:<br><br>1. Dementia,<br><br>2. Anxiety (feelings of fear or apprehension),<br><br>3. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows<br>(continued on next page) |

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| | 325040 | A. Building<br>B. Wing | 03/12/2026 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | to manic highs),<br><br>4. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),<br><br>5. Seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>J. Record review of R #9's physician record revealed:<br><br>1. An order dated 12/01/25 for Lorazepam oral tablet 0.5 mg to be given by mouth every four hours as needed for anxiety.<br><br>2. An order dated 12/19/25 for Temazepam oral capsule fifteen mg to be given by mouth as needed for insomnia (a common sleep disorder) at bedtime.<br><br>K. On 03/12/26 at 10:27 am, the DON confirmed the PRN psychotropic medications Lorazepam and Temazepam for R #9 did not have a stop date and did not have a rational to extend the use of the medications. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete an accurate Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment for 2 (R #9 and R #31) of 4 (R #5, R #9, R #11, and R #31) residents reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are: R #9A. Record review of R #31's physician's orders revealed an order dated 08/13/25 for Aspirin enteric coating (EC; Specialized barrier to oral medications to prevent dissolution in the acidic stomach) oral tablet eighty-one milligrams (mg) to be given by mouth in the morning for analgesic (pain medication).B. Record review of R #31's quarterly MDS assessment dated [DATE] revealed R #9 does not receive scheduled pain medications.C. On 3/12/25 at 10:03 am, during an interview with MDS Coordinator (MDS), she confirmed R #9 ?s quarterly MDS is inaccurate because she does take Aspirin for pain regularly.R #31D. Record review of R #31's physician order dated 09/22/23 for Depakote (anti-convulsant medication) tablet 250 milligrams mg to be given by mouth three times a day for major depressive disorder.E. Record review of R #31's quarterly MDS assessment dated [DATE] revealed R #31 does not take anticonvulsant medication. F. On 3/12/25 at 10:03 am, during an interview with MDS, she confirmed that Depakote is an anticonvulsant and the quarterly MDS for R #31 is inaccurate. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 2 (R #114 and R #115) of 4 (R #5, R #9, R #114 and R #115) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: R #114<br><br>A. Record review of R #114 admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),<br><br>2. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol),<br><br>3. Obstructive sleep apnea (OSA; a common sleep disorder),<br><br>B. Record review of R #114's electronic health record revealed no baseline care plan.<br><br>C. On 03/12/26 at 10:27 am, during an interview with the Director of Nursing (DON), she confirmed there was not a baseline care plan to include minimum healthcare information necessary to properly care for R #114 and this does not meet her expectations.<br><br>R #115<br><br>D. Record review of R #115's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Thrombosis of atrium (a condition where blood clots form in the atria of the heart), and ventricle as current complications following an acute myocardial infarction (heart attack),<br><br>2. Enterocolitis due to clostridium difficile (C. Diff.; a bacterium that causes inflammation of the colon and is primarily associated with antibiotic use),<br><br>3. Type 2 diabetes mellitus,<br><br>4. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),<br><br>5. Anxiety (feelings of fear or apprehension),<br><br>6. Epilepsy (a seizure disorder),<br><br>7. Retention of urine.<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | E. Record review of R #115's baseline care plan dated 03/09/26 revealed only the date was completed, no other information is included.<br><br>F. On 03/12/26 at 10:00 am, during an interview with the DON, she confirmed that R #115's baseline care plan does not meet her expectations because it should have been completed accurately and within 48 hours and it was not. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to ensure food was served under sanitary conditions when staff failed to follow safe food handling practices when they:1. Touched the rims of cups while serving residents' drinks.2. Failed to sanitize their hands after touching dirty (items that may be soiled or contaminated) and serving residents' meals. These deficient practices are likely to affect all 111 residents listed on the resident census list provided by the Administrator on 03/08/26 and are likely to lead to foodborne illnesses in residents if safe food handling practices are not adhered to and stored properly.The findings are:A. On 03/08/26 at 12:16 pm, an observation of the lunch dining services revealed the following:1. Licensed Vocational Nurse (LVN) #3 assisted R #82 into the dining area by holding her hand and walking with her. LVN #3 then served R #92 her lunch meal without washing or sanitizing her hands. 2. LVN #3 served R #47's meal and touched the cup by the top of the rim when placing it on the table.3. LVN #3 served R #36's meal and touched the cup by the top of the rim when placing it on the table.4. Certified Nurse Aide (CNA #1) assisted R #95 with putting on a clothing protector and then served R #155. Business Office Manager (BOM) served R #89's meal and touched the cup by the top of the rim when placing it on the table.6. BOM served R #107's meal and touched the cup by the top of the rim when placing it on the table.7. Hospitality Aide (HA) #1 touched R #2's shoulder and then served R #20 his lunch meal without washing or sainting his hands.B. On 03/08/26 at 12:47 pm during an interview with the Licensed Vocational Nurse (LVN) #1, he confirmed that staff should be sanitizing or washing their hands after touching dirty surfaces and handling food items and trays. LVN #1 stated that staff should never touch dishes by the rim when serving. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level I Identification Screen was accurate for 2 (R #68 and R #98) of 5 (R #1, R #2, R #10, R #68, and R #98) residents reviewed for PASARR screening. If the facility does not ensure PASARR screenings are completed accurately, then residents with serious mental illness may not receive required evaluations or specialized services, placing them at risk for unmet mental health needs and a decline in psychosocial well-being. The findings are:R #68<br><br>A. Record review of R #68's admission Record revealed R #68 was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Metabolic encephalopathy (is a change in how your brain works due to an underlying condition),<br><br>2. Generalized anxiety disorder (GAD; is a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things),<br><br>3. Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and Hemiparesis (one-sided muscle weakness) following 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) affecting right dominant side,<br><br>4. Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease).<br><br>B. Record review of R #68's PASARR form dated 08/23/25 revealed R #68 does not have a suspected mental illness diagnosis.<br><br>C. On 03/12/26 at 10:48 am, during an interview with the Director of Nursing (DON), she confirmed that the diagnosis of GAD should have been indicated on the PASARR form for R #68 and it was not.<br><br>R #98<br><br>D. Record review of R #98's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Alzheimer's disease (a progressive mental deterioration),<br><br>2. Encounter for therapeutic drug level monitoring,<br><br>3. Delusional disorders (a serious mental health condition characterized by persistent, false beliefs that are not based on reality),<br><br>4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation and anxiety (feelings of fear or apprehension),<br><br>5. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),<br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) with psychotic features (symptoms of psychosis such as delusions or hallucinations),<br><br>7. Anxiety disorder,<br><br>8. Obsessive compulsive disorder (a disorder that features unwanted thoughts and fears as obsessions),<br><br>9. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety),<br><br>10. Panic disorder (an anxiety disorder characterized by frequent and unexpected panic attacks).<br><br>E. Record review of R #98's hospital discharge paperwork dated 01/03/26 revealed R #98 was admitted to this behavioral health hospital on [DATE] and received in-patient care until her discharge on [DATE].<br><br>F. Record review of R #98's PASARR form dated 12/18/25 revealed R #98 does not have a diagnosis or suspected mental illness.<br><br>G. On 03/12/25 at 10:00 am, during an interview with the DON, she confirmed that R #98's PASARR form does not meet her expectations because it is not correct. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 2 (R #8 and R #59) of 8 (R #1, R #2, R #4, R #6, R #7, R #8, R #10, and R #59) residents reviewed when staff failed to: -Revise R #8's care plan using his name, not another resident's name.-Revise R #59's care plan to indicate a fall mat was in use.These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated accurately. The findings are:R #8<br><br>A. Record review of R #8's care plan, dated 02/17/26 revealed the following:<br><br>1. Focus areas for enhanced barrier precautions revealed Nursing to educate [Name of other resident] and/or family members on the evidence-based practice justification for utilizing enhanced barrier precautions when providing direct care.<br><br>2. Focus area for vision revealed the use of another resident's name in the interventions.<br><br>B. On 03/12/26 at 10:30 am, during an interview with the Director of Nursing (DON) she confirmed other residents' names were used in R #8's care plan.<br><br>R #59<br><br>C. Record Review of R #59's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:<br><br>Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),<br><br>Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks),<br><br>Age-related nuclear cataract (is the clouding and hardening of the central part of the eye's lens) right and left eye,<br><br>Generalized anxiety disorder (excessive, ongoing anxiety and worry that are difficult to control and interfere with day-to-day activities),<br><br>Insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep).<br><br>D. On 03/08/26 at 1:24 pm, during a random observation of R #59, R #59 was up walking around her room, and a fall mat was noted to be lying on the floor by R #59's bed.<br><br>E. Record review of R #59's care plan dated 12/02/25 revealed no indications that R #59 uses a fall mat.<br><br>F. On 03/12/26 at 10:50 am, during an interview with DON, she stated anytime a resident uses a fall mat, it must be included in the care plan. The DON confirmed R #59's care plan does not include the use of a fall mat. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #9) of 5 (R #2, R #4, R #8, R #9, and R #31) residents reviewed for respiratory care when the facility failed to ensure medical orders indicated when to administer R #9's oxygen. These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their conditions. The findings are:A. Record review of R #9's admission Record revealed R #9 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),3. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),4. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures),6. Chronic obstructive pulmonary disease (COPD; lung disease).B. Record review of R #9's physician order dated 02/24/26 for oxygen 1-3 liters per minute (LPM) per nasal cannula (flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) via oxygen concentrator (a medical device that concentrates oxygen and delivers it to someone that needs supplemental oxygen) and/or oxygen tank (aluminum or steel containers storing compressed oxygen for medical respiratory support).C. On 03/10/26 at 8:32 am during a random observation of the activity room, R #9 was observed wearing a nasal canula connected to a portable oxygen concentrator.D. On 03/12/26 at 10:27 am, during an interview with the Director of Nursing (DON), she confirmed R #9's order for oxygen use does not specify the frequency (as needed or continuous) that R #9 needs and it should. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to obtain appropriate physician orders prior to installation of bed rails for 1 (R #5) of 3 (R #5, R #11, and R #31) residents reviewed for bedrails. This deficient practice could result in the physician, staff, and residents not knowing the needs, risks and benefits of bed rails. The findings are:A. Record review of R #5's admission Record revealed R #5 was admitted to the facility on [DATE].B. Record review of R #5's physician orders revealed no order for the use of bedrails.C. On 03/09/26 at 2:12 pm, a random interview and observation of R #5's room revealed quarter size bedrail on the upper left side of the bed. R #5, he confirmed he uses the side rail for mobility and repositioning himself. D. On 03/12/26 at 10:27 am, during an interview with the Director of Nursing (DON), she confirmed the R #5 does not have physician orders for use of bedrails and should prior to installation of the bedrail. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325040 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Sands Healthcare | 5715 North Lovington Highway<br>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 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation and interview, the facility failed to post nurse staffing data daily at the beginning of the shift that included the following:- Facility name.-The current date.-The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.1. Registered nurse,2. Licensed practical nurse,3. Certified nurse aides,4. Resident census.The deficient practice has the potential to affect all 111 residents as identified by the census provided by the Administrator (ADM) on 03/08/26 and could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 03/09/26 at 10:01 am a random observation of the facility revealed the facility's staff data posting was dated 03/08/26.B. On 03/09/26 at 10:07 am, during an interview with the Registered Nurse (RN) #1, she confirmed the staff data posting was dated 03/08/26 and had not been updated. She confirmed it should be updated daily but was not. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325040 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2026 |
|---|---|---|---|

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

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all medications were not expired in the medication storage room. This deficient practice has the potential to affect any resident requiring emergency opioid overdose reversal by providing a medication with potentially reduced efficacy. The findings include:A. On [DATE] at 11:17 am, during an observation of the medication storage room, a vial of Naloxone 0.4 mg/ml, one milliliter (ml) as needed (PRN) injection was located in the medication refrigerator. The manufacturer's expiration date printed on the vial was 12/2025.B. On [DATE] at 11:30 am, during an interview with the Director of Nursing (DON), she confirmed the Naloxone vial was expired and stated it should have been removed from the refrigerator and placed in the designated pharmacy return or destruction area.C. A review of the facility's Medication Storage and Expiration pharmacy policy and procedure manual revised in 09/2010, revealed staff are required to audit medication storage areas on a regular basis and remove any medications that have reached their expiration date. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325040 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Sands Healthcare | 5715 North Lovington Highway<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain proper infection prevention measures for 2 (R #5 and R #115) of 4 (R #4, R #5, R #10, and R #115) residents reviewed by not:1. Ensuring Personal Protective Equipment (PPE) was properly used,2. Ensuring Enhanced Barrier Protection (EBP) signage is visibly posted and PPE is available near resident's room when precautions are in place.These deficiencies place residents at risk of contracting infections, hospitalization, and death. The findings are:<br><br>A. On 03/09/26 at 11: 42 am, during a random observation of the 300 hall, Certified Nurse Aide (CNA) #2 was observed exiting room [ROOM NUMBER] wearing a gown and gloves.<br><br>B. On 03/09/26 at 11:43 am during an interview with CNA #2, she confirmed she should not have exited the room wearing her PPE and is required to take off her PPE prior to exiting the room but did not.<br><br>C. On 03/09/26 at 1:37 pm during an interview with the Infection Prevention Coordinator (IPC). She stated that her expectation is for staff to don (put on) PPE prior to entering and doff (take off) prior to exiting the room. Staff should put on new PPE anytime they are re-entering the room to provide care.<br><br>D. On 03/08/26 at 9:37 am, a random observation of the facility revealed no signage or PPE available near R #115's door/room.<br><br>E. Record review of R #115's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:<br><br>1. Enterocolitis due to clostridium difficile (C. Diff.; a bacterium that causes inflammation of the colon and is primarily associated with antibiotic use),<br><br>2. Retention of urine.<br><br>F. On 03/08/26 at 10:22 am, during an observation and interview with R #115, a plastic tube connected to a bag collecting urine was observed on the side of R #115's leg. R #115 confirmed that he was admitted to the facility with the diagnosis of C. Diff. and with the use of a foley catheter (a thin, sterile tube inserted into the bladder to drain urine).<br><br>G. On 03/09/26 at 11:02 am, during an interview with Licensed Vocational Nurse (LVN) #2, he confirmed that EBP should be in place due to R #115's current use of a catheter and diagnosis of clostridium difficile. |