

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Desert Springs Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N Turner Street 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Past Noncompliance: Compliance Date was 04/06/24.</p> <p>Based on record review and interview, the facility failed to prevent an accident for 1 (R #1) of 1 (R #1) residents reviewed for falls, when the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure beds were fully locked. 2. Ensure staff was familiar with equipment. <p>These deficient practices resulted in R #1 falling and sustaining injuries that required treatment at the hospital. The findings are:</p> <p>A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Type 2 Diabetes. 2. Hyperlipidemia (high cholesterol). 3. Anxiety. 4. Heart Failure. <p>B. Record review of R #1's nursing progress notes revealed the following:</p> <ul style="list-style-type: none"> - On 03/21/24, staff documented the resident had a witnessed fall and landed face down. The resident fell out of bed while receiving a bed bath. Witness stated the resident did not lose consciousness when she landed on the floor. - On 03/22/24, staff documented that staff gave the resident a bed bath. When staff turned the resident to the left side, the resident braced herself against the wall. The bed moved, and the resident fell to the ground between the wall and the bed. The wheels at the top of the bed did not lock, but the brakes at the bottom of the bed were locked. Staff replaced bed, and all brakes lock. <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>C. Record review of R #1's Investigation Report (5 day report), dated 03/21/24, revealed a staff member gave R #1 a bed bath. The staff member turned the resident for the bed bath, and the resident got close to the edge of the bed. The resident fell off the bed to the ground and landed face first. The resident had pain to right arm and right eye swelling and bruising. An order was obtained to send R #1 to the emergency room for evaluation. The resident was transported to the hospital via Emergency Medical Services (EMS). Future preventative/corrective action for the resident's health and safety included the following:</p> <ul style="list-style-type: none"> - The staff member who gave R #1 the bed bath was in-serviced on proper use of the bed, proper use of bed brakes, and proper positioning of residents during a bed bath for safety. - Staff completed a building wide sweep on residents' beds to ensure brakes were in proper condition for use, and all bed brakes were determined to be in proper working order. - Certified Nursing Assistants (CNAs) were in-serviced on the use of the bed brakes used for all resident beds in the facility. - R #1 returned from the hospital on 03/25/24 and was on therapy services for the fractured humerus (arm). - Trauma assessment was completed for R #1. <p>D. Record review of R #1's care plan, initiated on 11/02/23 and revised on 03/26/24, revealed the following:</p> <ul style="list-style-type: none"> - Focus: R #1 was at risk for falls related to weakness and history of falls. - Interventions: Replace bed (updated on 03/26/24). Review information on past falls and attempt to determine cause of falls. Record possible root causes. Remove any potential causes if possible. Educate resident/family/caregivers as to causes. Transfers: Requires total physical assistance with 2 staff. <p>E. Record review of R #1's Minimum Data Set (MDS) Section GG (Functional Abilities and Goals), dated 04/26/24, revealed the following:</p> <ul style="list-style-type: none"> -R #1 requires maximal assistance to roll between her left and right side. -R #1 requires maximal assistance when moving from sitting on the side of the bed to lying flat on the bed. - R #1 requires maximal assistance when moving from lying flat on the bed to sitting on the side of the bed. <p>F. On 05/16/24 at 4:12 pm during an interview with R #1, she stated she was in her bed and not all of the bed wheels were locked. R #1 also stated the bed started to move, and she fell to the floor and broke her arm. R #1 confirmed her bed was replaced when she returned from the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>G. On 05/16/24 at 5:03 pm during an interview with CNA #1, she stated she gave R #1 a bed bath, and she made sure all the brakes on the bed were locked. She stated she had R #1 roll over to the side, so she could put the new bed sheet on while R #1 held onto the wall. CNA #1 also stated R #1's bed was in a higher position due to the bed bath. She stated R #1's bed slid toward her (CNA #1), causing R #1 to fall on the floor.</p> <p>H. On 05/17/24 at 12:34 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated CNA #1 told her that not all of R #1's bed wheels were locked on 03/21/24. LPN #1 also stated when CNA #1 had R #1 roll onto her side, the bed started moving, and this caused the bed to slide out from under R #1. She stated R #1 fell to the ground. LPN #1 stated this had never happened before. She said R #1 was assessed and sent to the emergency room .</p> <p>I. On 05/17/24 at 1:04 pm during an interview with the Administrator (ADM), she stated the bed wheels were not aligned on R #1's bed, causing the bed wheels to not lock. The ADM confirmed the facility educated all nursing staff, checked every bed, and replaced the style of bed R #1 previously used.</p> <p>J. On 05/17/24 at 1:05 pm during an interview with the Director of Nursing (DON), she stated R #1's bed wheels did lock on the top; however, CNA #1 did not have R #1's bed wheels aligned properly so the top brakes did not lock at the time of the incident.</p>		