STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325129	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Health Care LLC	1701 N Turner Street Hobbs, NM 88240

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure residents were provided with a choice about aspects of his/her life that are significant to the residents for 1 (R #27) of 3 (R #3, R #27 and R #91) residents by not having a choice to refuse dietician orders. If the facility does not honor residents' choices, then residents are likely to experience a loss of independence and self-worth leading to feelings of frustration and depression.The findings are:A. Record review of R #27's admission record revealed R #27 was admitted into the facility on [DATE] with the following diagnoses:1. Traumatic subdural hemorrhage (SDH; often life-threatening brain injury involving bleeding typically caused during head trauma),2. Anemia (low red blood cell count),3. Retention of Urine (the inability to fully empty the bladder),4. Repeated falls.B. Record review of R #27's Quarterly [NAME] Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 01/12/26 revealed R #27's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) is 12 (8-12 suggests moderate impairment).C. Record review of R #27's dietician orders dated 01/09/26 revealed an order for R #27 to be on a regular diet, soft and bite-sized texture and thin liquid consistency. D. On 01/28/26 at 12:52 pm, during a random observation of the dining room, R #27 asked for a tortilla. R #27 was informed that he could not have a tortilla due to his diet order. R #27 pushed his plate away and did not eat his meal.E. On 01/28/26 at 3:59 pm during an interview with R #27, he stated he really wants to eat a tortilla. He stated that he was told he could not have a tortilla because he might choke. R #27 stated he understands the risks and still wants a tortilla.F. On 01/30/26 at 4:26 pm, during an interview with the Director of Nursing (DON), she confirmed R #27 is on a soft, bite-sized diet. She confirmed R #27 has the right to refuse his dietary orders. She stated the staff should have communicated with the nurse or dietician to provide the opportunity for R #27 to refuse his dietary orders so he could have a tortilla.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's current advance directive (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of health care when the individual is incapacitated) and New Mexico Orders for Scope of Treatment (MOST) form (a document which provides an individual's wishes for emergency and lifesaving care) matched the order in the electronic health record (EHR) for 2 (R #5 and R #39) of 7(R #5, R #6, R #8, R #9, R #10, R #12, and R #39) residents reviewed for advance directives when staff failed to update the resident's code status. This deficient practice is likely to result in confusion, delay, and residents not having their wishes honored if a life-threatening event occurred. The findings are:R #5A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE]. B. Record review of R #5's physician orders dated [DATE], revealed R #5 is a Full Code [attempt cardiopulmonary resuscitation (CPR; full code, an emergency procedure that combines chest compression with artificial ventilation)] for his advanced directive code status.C. Record review of R #5's current advance directive and the MOST form signed on [DATE] revealed R #5 chose a do not resuscitate (DNR; does not want to have CPR attempted on them if their heart or breathing stops) for his advanced directive code status.D. On [DATE] at 4:30 pm during an interview with the Director of Nursing (DON), she stated R #5's code status should be DNR and not full code, confirming the inaccuracy. R #39E. Record review of R #39's admission Record revealed she was admitted to the facility on [DATE].F. Record review of R #39's current medical orders revealed an order dated [DATE] to not attempt resuscitation due to DNR status.G. Record review of R #39's MOST form dated [DATE] revealed R #39 chose to be a full code and wants CPR performed if needed.H. On [DATE] at 4:23 pm, during an interview with the DON, she stated this does not meet her expectations because R #39's order should match her MOST form and it does not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 1 (R #42) of 3 (R #2, R #3, and R #42) residents reviewed for assessments. This deficient practice could likely result in the residents' preferences and care needs not being met.The findings are: A. Record review of R #42's admission record revealed he was admitted on [DATE].B. Record review of R #42's physician record revealed the following:1. An order dated 07/04/25 for Zoloft Oral Tablet (antidepressant medication) 100 milligrams (MG). Give 1.5 tablet by mouth one time a day for depression.2. An order dated 09/10/25 for Depakote Sprinkles (anticonvulsant medication) Oral Capsule 125 milligrams (MG). Give two capsules by mouth two times a day for dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with behaviors.3. An order dated 12/20/24 for Gabapentin capsule (anticonvulsant medication) 300 milligrams (MG). Give one capsule by mouth two times a day for anxiety (feelings of fear or apprehension).4. An order dated 12/20/24 for Aspirin oral tablet (antiplatelet medication) 81 milligrams (MG). Give one tablet by mouth one time a day for prophylactic measures related to history of stroke. Start date 12/20/24.5. An order dated 12/20/24 for Clopidogrel Bisulfate Oral Tablet (antiplatelet medication) 75 milligrams (MG). Give 1 tablet by mouth one time a day for prophylactic (intended to prevent) measures related to history of stroke (sudden interruption of blood flow to the brain).C. Record review of R #42's MDS dated [DATE], revealed Section N-Medications indicated R #27 does not take antidepressant medications, anticonvulsant medications or antiplatelet medications.D. On 01/30/26 at 4:40 pm during an interview with the MDS coordinator, she confirmed the assessment for R #42 was inaccurate and should include the use of antidepressant, anticonvulsant and antiplatelet medications but it does not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours for 1 (R #11) of 6 (R #1, R #2, R #7, R #8, R #9, and R #11) residents reviewed for baseline care plans. If the facility fails to develop and implement a baseline care plan, then residents might not get the care and services they need. The findings are: A. Record review of R #11's admission Record revealed she was admitted to the facility on [DATE].B. Record review of R #11's Electronic Health Record (EHR) revealed no evidence of a baseline care plan.C. Record review of R #11's care plan revealed the care plan was developed and implemented on 10/27/25.D. On 01/30/26 at 4:16 pm, during an interview with the Director of Nursing (DON), she confirmed the facility failed to develop and implement a baseline care plan for R #11. The DON stated that she expects every resident to have a baseline care plan developed and implemented within 48 hours of being admitted to the facility.

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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 1 (R #91) of 4 (R #2, R #3, R #42, and R #91) residents reviewed for care plans when staff failed to: 1. Develop a care plan to include interventions for R #91's use of oxygen.2. Develop a care plan to include interventions for R #91's use of floor mat.This deficient practice could likely result in proper care not being provided to residents.The findings are: A. Record review of R #91's admission record revealed R #91 was admitted into the facility on [DATE].B. Record review of R #91's care plan dated 01/25/26 revealed the following:1. There was no care plan to include intervention for the use of supplemental oxygen (extra oxygen required to support the body's vital functions),2. There was no care plan to include interventions for the use of a floor mat.C. Record review of R #91's current medical orders revealed the following:1. An order dated 01/29/26 for this resident to use supplemental oxygen via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs).2. There was no order for this resident's use of a fall mat.D. On 01/29/25 at 12:43 pm, during a random observation of R #91's room revealed R #91 was lying in bed wearing a nasal canula connected to an oxygen concentrator (a medical device that provides supplemental oxygen). There was a floor mat on the floor next to the right side of the bed.E. On 01/29/26 at 12:48 pm during an interview with the Assistant Director of Nursing (ADON), she confirmed R #91 was wearing oxygen and had a floor mat placed on the floor next to the bed.F. On 01/30/26 at 4:26 pm during an interview with the Director of Nursing (DON), she confirmed R #91's use of oxygen and floor mat and confirmed both should be included in a care plan with interventions prior to use and was not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **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 1 (R #3) of 5 (R #2, R #3, R #27, R #34 and R #55) residents reviewed when staff failed to revise the care plan to include the current use of oxygen interventions. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: A. Record review of R #3's admission record revealed R #3 was admitted into the facility on [DATE] with the following diagnoses:1. Chronic Obstructive Pulmonary Disease (COPD; a progressive lung condition causing airflow blockage and breathing difficulties),2. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),3. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),B. Record review of R #3's physician record revealed an order dated 08/14/25 for oxygen through nasal canula (a small, flexible tube that delivers oxygen to the nose through soft prongs) at two liters (L) to keep oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood) above 90% (percent).C. Record review of R #3's care plan revised on 12/31/25 revealed R #3 uses oxygen through nasal cannula at two liters continuously.D. On 01/28/26 at 1:42 pm, an observation and interview with R #3 in her room revealed R #3 had an oxygen concentrator next to the bed. R #3 was not wearing an oxygen cannula, and the machine was not on. R #3 she stated she only wears her oxygen when she needs it.E. On 01/30/26 at 4:26 pm during an interview with the Director of Nursing she confirmed R #3 only wears her oxygen as needed. She confirmed the care plan was not accurate and should have been revised.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate foot care services for 1 (R #77) of 1 (R #77) resident reviewed for toenail care. This deficient practice could likely result in functional decline, pain, and infections. The findings are: A. Record review of R #77's face sheet indicated she was admitted on [DATE] with the following diagnoses: 1. Metabolic encephalopathy (brain dysfunction caused by metabolic disturbances in the body, leading to symptoms such as confusion, memory loss, and altered consciousness),2. Chronic kidney disease (a condition characterized by the gradual loss of kidney function over time, leading to the accumulation of waste and excess fluid in the body),3. Muscle weakness (generalized),4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),5. Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain),6. Repeated falls.B. On 01/30/26 at 11:30 am, during an observation of wound care to R #77's right ankle, Licensed Practical Nurse (LPN) #1 removed R #77's sock revealing an overgrown toenail to right great toe that was curving in slightly to the second toe.C. On 01/30/26 at 11:45 am, during an interview with LPN #1, she confirmed quarterly podiatry (the treatment of the feet and their ailments) appointments are made to provide nail care and would expect Certified Nurse Aides (CNA's), nurses or the providers to trim nails in between podiatry appointments. She also confirmed R #77's appointment with podiatry is scheduled for 02/09/26.D. On 01/30/26 at 4:30 pm, during an interview with the Director of Nursing (DON), she stated CNA's nurses, or the providers, should ensure nails do not become overgrown because the condition of R #77's toenail does not meet her expectation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent an accident for 1 (R #81) of 3 (R #4, R #37, and R #81) residents reviewed for falls when staff failed to provide the required assistance during personal care resulting in R #81 falling from her bed. This deficient practice resulted in R #81 sustaining a fractured (broke) femur (thigh bone) and a fractured finger. The findings are:A. Record review of R #81's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Chronic, systolic (congestive) heart failure (impaired heart function),2. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),3. Morbid (severe) obesity (severely overweight),4. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),5. Muscle weakness generalized (reduction in the power exerted by muscles).B. Record review of R #81's care plan revised on 06/03/25 revealed R #81 needs two-person assistance (assistance by two staff members) for the following activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating):1. Bathing and showering,2. Bed mobility,3. Dressing,4. Toilet use,5. Transfers, using a Hoyer lift (a device designed to help staff move a resident from one place to another within a room or from one position to another).C. Record review of R #81's progress notes dated 12/27/25 revealed R #81 was in her room with her husband and requested a bed bath. R #81 fell from her bed while getting a bed bath, had a laceration (a wound produced by tearing) on her left pinky finger and complained of pain to her left arm, leg, and hip. R #81 was sent via ambulance to a local hospital for evaluation where she was diagnosed with a displaced oblique fracture (where the bone breaks at an angle) along the distal aspect of the femur (the lower end of the bone) and a displaced fracture (a break where the bone fragments have moved and are not aligned) of the middle phalanx of the fifth finger (pinky finger).D. On 01/29/26 at 1:18 pm, during an interview with Certified Nurse Aide (CNA) #2, he stated that on 12/27/25 he was called to R #81's room where she was lying in her bed demanding a bed bath. CNA #2 stated he greeted R #81 and R #81's husband and then assisted R #81 with a bed bath. During this bed bath, CNA #2 stated he was on one side of the bed, completing the bed bath when R #81 rolled to the opposite side of the bed and he was unable to stop her from rolling out of the bed and she fell to the floor. CNA #2 stated that he assisted R #81 without a second staff because he was unaware that R #81 required two-person assistance.E. On 01/29/26 at 1:37 pm, during an interview with the Director of Nursing (DON), she stated she expects residents who require two-person assistance to receive assistance from two staff members, following the care plan. The DON stated CNA #2 should have been told that R #81 requires two-person assistance when he received report from the nurse at the beginning of his shift.F. Record review of R #81's hospital documentation dated 01/05/26 revealed the following:1. R #81 was admitted to the hospital for femoral fracture and left fifth digit fracture.2. R #81 underwent surgery to repair the fractures on 12/29/25.G. On 01/29/26 at 2:30 pm, during an interview with the Administrator (ADM), she confirmed that R #81 was transferred to a rehabilitation facility (a facility designed to help people recover and regain abilities after an injury or surgery) after being discharged from the hospital and has not returned to the facility yet.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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 3 (R #3, R #39, and R #91) of 4 (R #1, R #3, R #39, and R #91) residents reviewed for respiratory care when staff failed to:1. Ensure medical orders indicated when to administer supplemental oxygen (extra oxygen required to support the body's vital functions) needed to R #3 and R #39.2. Ensure a medical order was in place for R #91's supplemental oxygen use. 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: R #3A. Record review of R #3's admission record revealed R #3 was admitted into the facility on [DATE] with the following diagnoses:1. Chronic Obstructive Pulmonary Disease (COPD; a progressive lung condition causing airflow blockage and breathing difficulties),2. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),3. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),B. Record review of R #3's physician record revealed an order dated 08/14/25 for oxygen through nasal canula (a small, flexible tube that delivers oxygen to the nose through soft prongs) at two liters (L) to keep oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood) above 90% (percent).C. On 01/28/26 at 1:42 pm an interview and observation of R #3 in his room revealed an oxygen concentrator (medical device that delivers supplemental oxygen) next to the bed. R #3 was not wearing her oxygen cannula, and the machine was not on R #3 stated she only wears her oxygen when she needs it.D. On 01/30/26 at 4:26 pm during an interview with the Director of Nursing, she confirmed R #3 only wears oxygen as needed. She confirmed the order does not specify when R #3 should wear oxygen and it should.R #39F. Record review of R #39's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Congestive heart failure (CHF; impaired heart function),2. Chronic respiratory failure with hypoxia (an inability to exchange oxygen and carbon dioxide in the body),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),4. Unspecified atrial fibrillation (A-Fib; irregular heart rhythm),5. Sleep apnea (sleep disorder that occurs when a person's breathing is interrupted during sleep).6. Atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls).G. Record review of R #39's current medical orders revealed an order dated 10/21/24 for R #39 to receive two liters of oxygen via nasal cannula, may titrate to maintain oxygen level at 92% (percent).H. On 01/28/26 at 1:42 pm, during an interview with the DON, she confirmed that R #39's order for oxygen does not specify when to administer (continuous or PRN) oxygen to R #39 and it should.R #91I. Record review of R #91's admission record revealed R #91 was admitted into the facility on [DATE] with the following diagnoses:1. Hypertension (high blood pressure),2. Kidney failure (loss of kidney function),3. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),4. Cellulitis (deep inflammation of the tissues just under the skin; caused by infection) of right lower limb,5. Metabolic encephalopathy (non-traumatic brain dysfunction).J. On 01/29/25 at 12:43 pm, a random observation of R #91's room revealed R #91 was lying in bed wearing a nasal canula connected to an oxygen concentrator.K. On 01/29/26 at 12:48pm during an interview with the Assistant Director of Nursing (ADON), she confirmed R #91 was wearing oxygen.L. On 01/30/26 at 4:26 pm during an interview with the DON, she confirmed R #91's should have an order for use of oxygen prior to use and did not.

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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 was free from unnecessary drugs by ensuring medications have an adequate indication of use and ensuring indication of use is based off of the residents' current diagnosis for 2 (R #7 and R #11) of 5 (R #2, R #3, R #6, R #7, and R #11) residents reviewed for unnecessary medications. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are: R #7A. Record review of R #7's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the artery walls),2. Alzheimer's disease (progressive mental deterioration due to generalized degeneration of the brain),3. Atherosclerosis of coronary artery bypass grafts (plaque containing cholesterol and lipids that build up on artery walls),4. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),5. Chronic kidney disease (CKD; impaired kidney function). B. Record review of R #7's current medical orders revealed an order dated 08/06/25 for Apixaban (a medication used to lower the risk of a stoke) oral tablet, 2.5 milligrams (mg) to be given twice daily for atrial fibrillation (A-Fib; irregular heart rhythm).C. On 01/30/26 at 4:21 pm, during an interview with the Director of Nursing (DON), she confirmed R #7 does not have a diagnosis of A-Fib. The DON stated this does not meet her expectations because medications should be ordered and administered for diagnoses the resident has and this is not.R #11D. Record review of R #11's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),3. Essential (primary) hypertension (HTN; high blood pressure),4. Chronic obstructive pulmonary disease (COPD; lung disease),5. Rheumatoid arthritis (RA; chronic joint disease that causes pain and swelling).E. Record review of R #11's current medical orders revealed the following:1. An order dated 10/24/25 for Memantine HCl Oral Tablet 10 MG (a medication used to treat Alzheimer's disease), give two tablets by mouth at bedtime for Alzheimer's disease.2. An order dated 10/24/25 for Aricept Oral Tablet 10 MG (a medication used to treat Alzheimer's disease), give one tablet by mouth at bedtime for Alzheimer's disease.F. On 01/30/26 at 4:18 pm, during an interview with the DON, she confirmed R #11 does not have a diagnosis of Alzheimer's disease. The DON stated this does not meet her expectations because medications should only be ordered and administered for diagnoses the resident has.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325129	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Health Care LLC	1701 N Turner Street Hobbs, NM 88240

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were updated and accurate for 1 (R #6) of 5 (R #1, R #3, R #6, R #27, and R #55) residents reviewed, when the facility failed to document an updated consent ordered by physician. This deficient practice is likely to result in residents having an inaccurate medical record, which could result in the residents receiving less than optimal care and treatment. The findings are:A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE] with the following diagnoses:1. Type 2 Diabetes Mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),2. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),3. Anxiety (feelings of fear or apprehension),4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).B. Record review of R #6's Medication Regimen Review Recommendations form pharmacist dated 11/26/25 stated a consent could not be found for this resident's Risperidone (an antipsychotic medication used to treat various mental health disorders) for a diagnosis of dementia with behavior disturbance, and to update the resident records to reflect when consent is obtained.C. Record review of R #6's current consent for Risperidone dated 08/26/24 is for the diagnosis of schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly).D. Record review of physician orders dated 10/20/25, revealed the indicated use for Risperidone is dementia, unspecified severity, without other behavioral disturbance.E. On 01/30/25 at 4:00 pm, during an interview, the MDS (Minimum Data Set) regional coordinator confirmed that the consent does not match the physician's orders and stated the consent should be updated to match the current order.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) by not ensuring Enhanced Barrier (EBP) signs are posted outside of rooms with Personal Protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) readily available for 2 (R #37 and R #91) of 7 (R #2, R #5, R #8, R #9, R #10, R #37 and R #91) residents reviewed. These deficiencies place residents at risk of contracting infections, hospitalization, and death. The findings are:R #37A. Record review of R #37's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Focal traumatic brain injury (an external force causes localized damage to an area of the brain),2. Zoster (shingles),3. Elevated white blood cell count (typically means the body is responding to some form of stress or infection).B. Record review of R #37's current medical orders revealed an order dated 01/13/26 for this resident to be on contact precautions (used for individuals with infections that can spread through direct or indirect contact with the patient or their environment) due to shingles. The order stated Resident has active infection with highly transmissible/epidemiologically significant pathogens (easily spread from person to person) acquired by physical contact.C. On 01/28/26 at 1:49 pm, an observation of R #37's room revealed R #37 did not have a sign indicating contact precautions were required on her door. There was no PPE readily accessible.R #91D. Record review of R #91's admission record revealed R #91 was admitted into the facility on [DATE] with the following diagnoses:1. Hypertension (high blood pressure),2. Kidney failure (loss of kidney function),3. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),4. Cellulitis (deep inflammation of the tissues just under the skin; caused by infection) of right lower limb,5. Metabolic encephalopathy (non-traumatic brain dysfunction).E. Record review of R #91's physician orders revealed the following:1. An order dated 01/23/26 for wound care to the left hip, unstageable (a full-thickness, serious wound covered by necrotic tissue that obscures the depth, making it impossible to determine if it is stage 3 (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) or stage 4 (a deep wound that may impact muscle, tendons, ligaments, and bone), cleanse with wound cleanser, pat dry, apply honey to wound, cover with border gauze, change daily/as needed (PRN).2. An order dated 01/23/26 for wound care to the right ischium (lower-back bone of the pelvis), unstageable, cleanse with wound cleanser, pat dry, apply honey to wound, cover with border gauze, change daily/as needed (PRN).3. An order dated 01/23/26 for wound care to the left ischium, stage 3 (wound extending through the skin into the subcutaneous fat tissue, often appearing as a deep, crater-like crater), cleanse with wound cleanser, pat dry, apply honey to wound, cover with border gauze, change daily/as needed (PRN).4. An order dated 01/23/26 for wound care to the left heal, deep tissue injury (DTI; a serious form of pressure injury where damage occurs to underlying soft tissue (muscle/fat) beneath intact skin), cleanse with wound cleanser, pat dry, apply skin prep to wound, keep open to air daily/as needed (PRN).5. An order dated 01/23/26 for wound care to the right heal, unstageable, cleanse with wound cleanser, pat dry, apply betadine to wound, cover with border gauze, change daily/as needed (PRN).6. An order dated 01/23/26 for wound care to the sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis), unstageable, cleanse with wound cleanser, pat dry, apply honey to wound, cover with border gauze, change daily/as needed (PRN).7. An order dated 01/23/26 for wound care to the right big toe, unstageable, cleanse with wound cleanser, pat dry, apply betadine to wound, cover with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	border gauze, change daily/as needed (PRN).F. On 01/28/25 at 1:29 pm a random observation of R #91's room revealed R #91 did not have an EBP sign.G. On 01/30/26 at 11:28 am during an interview with the Certified Nurse Aide (CNA) #1, she confirmed R #91 did not have EBP sign posted.