STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675145	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab Odessa	3800 Englewood LN Odessa, TX 79762

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 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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive person-centered care plan based on assessed needs with measurable objectives that could be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #3) of 3 residents reviewed for comprehensive person-centered care plans. The facility failed to develop care plans based on the assessed needs with measurable objectives and timeframes for using a Geri chair for mobility for Resident #3. This failure could place the residents at risk of a decreased quality of life, and not having their needs met.Findings included: Record review of Resident #3's electronic face sheet 011/6/2025 revealed [AGE] year-old male admitted [DATE] and diagnoses included nontraumatic intracranial hemorrhage (bleeding within the brain that is not caused by trauma), (a condition where paralysis or weakness affects the right side of the body due to damage to the left dominant hemisphere of the brain), muscle weakness (a condition characterized by a decreased ability to generate force in muscles), altered mental status (a significant change in a person's cognitive function, resulting in a decreased level of consciousness and awareness. Record review of Resident #3's Quarterly MDS dated [DATE] revealed resident was sometimes understood and understands others, Resident #3's BIMS (Brief Interview of Mental status) score 0 indicating severe cognitive impairment. Section GG of MDS revealed resident uses a manual wheelchair for mobility. Section O indicated Resident #3 was receiving physical therapy. Section P indicated no restraints were being used. Record review of Resident #3's Care Plan dated 7/302025 revealed no documented Focus, Goal, or Interventions for using a Geri chair (a specialized medical recliner for people with limited mobility to provide comfort, support, and ease of transportation for mobility for Resident #3). Observation on 10/31/2025 at 10:30AM upon entrance to facility Resident #3 was sitting in Geri chair in front lobby. Observation on 10/31/2025 at 12:01PM revealed Resident #3 sitting at dining room table in Geri chair feeding himself. Observation on 10/31/2025 at 1:58 PM revealed Resident #3 in his room in Geri chair in front of TV with call light on. Call light was answered at 2:09PM. Observation on 11/6/2025 at 10:17AM staff was pushing Resident #3 Geri chair down hallway. Interview on 10/31/2025 at 12:00PM with Director of Rehab revealed Resident #3 is currently receiving physical therapy for contractures and standing. Director of Rehab stated he has attempted to use a wheelchair for Resident #3 but resident has poor trunk control. Director of Rehab stated when Resident #3 is in wheelchair nursing staff states he leans forward and tries to get up. Director of Rehab stated Resident #3 has right side hemiplegia (paralysis and weakness on the right side of the body) and the right leg is flaccid (soft and hanging loosely). Director of Rehab stated Resident #3 requires assistance of 2 staff members for most ADLs. Director of Rehab stated he does think resident will progress out of the Geri chair when therapy is completed. Interview on 10/31/2025 at 3:00PM with Regional Nurse Consultant revealed facility does not have a policy on use of Geri chairs. Regional Nurse Consultant stated he would expect Geri chairs to be care planned because that is what residents use for mobility. Also stated the interdisciplinary team is responsible for ensuring the goals/interventions are met. Interview on 11/6/2025 at 2:41PM with LVN C she stated Resident #3 uses a Geri chair. She stated Resident #3 has had several falls from bed and wheelchair. During an interview on 11/6/2025 at 3:26 PM with MDS Coordinator stated the facility completed care plans as a team and each department did their section. The MDS Coordinator stated she would expect for the Geri chair to be care planned and she did not know how the failure occurred. The MDS coordinator stated the DON usually updates changes on the care plan to reflect residents' condition within 3 days. The MDS Coordinator stated this failure could impact the resident's quality of life, and safety by staff not recognizing that Resident #3 utilized a Geri chair for mobility. During an interview on 11/6/2025 at 3:46PM the DON stated the MDS coordinator updates all comprehensive care plans. The DON stated it was her responsibility to update acute care plans. The DON stated she was responsible for checking care plans quarterly and when a resident had a change in condition that required additional interventions on care plan. She stated she updates the care plans as needed. She stated a risk for not having this care planned is staff might not know the resident utilizes a Geri chair. Record review of facility's policy titled Comprehensive Care Planning (not dated) revealed:The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights that include measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the appropriate treatment and services to prevent complications was provided for 1 of 1 resident reviewed for feeding tube management (Resident #1). The facility failed to ensure Resident #1 had a physician order for the volume, frequency, and type of flush to administer via the gastrostomy feeding tube (a surgically created abdominal opening into the stomach for the purpose of administering feedings). The facility failed to ensure Resident #1 had a physician order on the frequency of cleaning and the care of the site on the gastrostomy feeding tube. These failures placed the resident at risk for tube obstruction, malfunction, dysfunction, abdominal discomfort, and infection.Findings included: Record review of Resident #1's face sheet dated 10/31/25 revealed Resident #1 was a [AGE] year-old female admitted on [DATE]. Resident #1 had diagnoses including unspecified protein-calorie malnutrition (is a condition caused by an inadequate intake of protein and calories, leading to a deficiency in essential nutrients and impacting body composition and function), dysphagia (difficulty swallowing), Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination), abnormal weight loss (a significant decrease in body weight without intentional effort). Record review of Resident #1's annual MDS assessment dated [DATE] revealed Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 8 which indicated moderate cognitive impairment. Section K of MDS revealed Resident #1 had received mechanically altered diet and therapeutic diet while a resident was not receiving gastrostomy tube feedings (is a method of providing nutrition and fluids directly into the stomach or small intestine through a tube) during last 7 days while a resident. Section K also revealed no significant weight loss or weight gain in the last 180 days. Record review of Resident #1's care plan dated 10/16/25 revealed Resident #1 had a puree diet with nectar thickened liquids. Care plan also revealed resident requires tube feeding related to dysphagia but chooses to eat by mouth instead of tube feeding. Interventions include cleanse insertion site daily, monitor for signs and symptoms of infection or skin breakdown, and monitor/document report to MD as needed infection at tube site, tube dysfunction or malfunction, resident is dependent with flushes. Record review of Resident #1's consolidated physician order dated 8/1/25 revealed all enteral feed orders were discontinued on 8/3/2025. Resident #1 continued with gastrostomy tube even though she was not receiving nutrition via tube. Record review of Resident #1's Medication administration record and treatment administration record revealed no enteral feeding care including flushes to maintain patency and monitor for malfunction or site care was administered from 8/3/2025 to 10/23/2025 when Resident #1 discharged to the hospital. Record review of facility in-service to staff dated 10/28/2025 conducted by Regional Nurse Consultant revealed: If feedings are discontinued and the peg tube is not removed staff must keep the peg tube patent by flushing every shift and continue to monitor and treat the site of the feeding tube until it is removed by the physician. At no time should a peg tube not in use not have an order to continue flushing or monitoring. Interview on 10/31/25 at 3:30 p.m., LVN G said she primarily worked on the hall where Resident #1 resided. She said the nurses are responsible for obtaining feeding tube orders. She said residents with feeding tubes should have flush orders and cleaning orders. She said Resident #1 often declined feeding and requested to eat food by mouth. She stated Resident #1 typically had a good appetite and ate most of her food on her shift. She said it was important to clean the gastrostomy site to prevent infections. She said it was important to have physician orders because some staff may come through and not follow the best nursing practices. She stated they have not provided gastrostomy care in a while as resident did not want them messing with it. She stated she did not realize the orders were discontinued. Interview on 11/6/2025 at 11:04 AM with Resident #1's Primary Care Physician he stated if gastrostomy tube feedings were discontinued, he would expect general maintenance such as flushing tube every shift to maintain patency (the condition of not being blocked or obstructed) and management of site skin care to continue. He stated not managing or monitoring the gastrostomy tube site could lead to skin breakdown infection, and stomach pain. Interview on 11/6/25 at 3:15 PM, the DON stated the nurse was responsible for obtaining physician orders for a resident with a feeding tube. She stated nursing management was responsible for ensuring the nurses obtained physician orders. She was unaware the orders to flush and cleanse site were discontinued. She stated she monitors new orders put into system in the morning clinical meeting. She uses a report pulled from the electronic medical record system of any new orders that have been put into computer. She was aware the feeding orders were discontinued. She