

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Buena Vida Nursing and Rehab Odessa		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #81) reviewed for transfers in that: CNA D and LVN C transferred Resident #81 from her bed to her wheelchair by grabbing her from the back of her pants and her under arms. These failures could put residents at risk of accidents and injuries which could result in a reduced quality of life. Findings included: Record review of Resident #81's admission record dated 08/07/2025 indicated she was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and paraplegia. (Paraplegia is the loss of muscle function in the lower half of the body, including both legs). She was [AGE] years of age. (Paraplegia is the loss of muscle function in the lower half of the body, including both legs). Record review of Resident #81's MDS assessment dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making = Moderately impaired. Functional Abilities - Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) = Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of Resident #27's 81's care plan dated 04/17/2025 indicated in part: Focus: The resident has an ADL Self Care Performance Deficit. Goal: The resident will maintain or improve current level of function in (Specify Bed Mobility, Transfers,. Interventions: Transferring: requires staff x2 for assistance During an observation on 08/05/2025 at 12:02 PM CNA D and LVN C transferred Resident #81 from her bed to her wheelchair. Both staff members took the resident from under her arm pits and the back of her pants to transfer her. Resident #81 did not appear to have been bearing weight during the transfer as her legs were partially contracted. During an interview on 08/08/2025 at 8:58 AM LVN C said that she had not transferred Resident #81 safely from her bed to her wheelchair. LVN C said she should have used a gait belt but had forgotten to use one. LVN C said if they did not use a gait belt then it could possibly lead to accidents such as dropping the resident or they themselves getting hurt. During an interview on 08/08/2025 at 9:04 AM CNA D said she should have used a gait belt when they transferred Resident #81 from her bed to the wheelchair. CNA D said she had not used a gait belt because she did not have one readily available and she should have had one. CNA D said they could have dropped or injured the resident by not using a gait belt. During an interview on 08/07/2025 at 04:38 PM the DON said the CNA and nurse should have used a gait belt to transfer Resident #81. The DON said staff used the gait belts to prevent falls or injuries. The DON said the failure probably occurred because the staff got nervous and forgot to use the gait belt. During an interview on 08/07/2025 at 05:12 PM the Administrator said the nursing staff was expected to use a gait belt when transferring residents manually. The Administrator said the nursing staff should have not taken Resident #81 from the back of her pants as that could make the transfer uncomfortable for the resident plus the staff could have dropped her. Review of the facility's undated policy titled Moving a resident bed to chair/chair to bed indicated in part: Purpose - The purposes of this procedure are to allow the resident to be out of his or her bed as much as possible and to provide for safe transferring of the resident. Steps in the procedure. This procedure may require two (2) persons. Position a gait belt around the resident's waist and clasp it. Make sure it is tight enough that only a slight hand movement will guide the patient, but not so tight that you cannot firmly grasp the belt without making the patient uncomfortable. If the resident requires two person (one on each side) should grasp the gait belt and gently stand and turn the resident and sit him or her on the edge of the bed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 3 of 3 medication carts (#1, #2 and #3) reviewed for medication storage. The nurse medication carts used for halls 100, 200, 300 and 400 had an insulin vial that had been opened but had no open date. There were insulin pens that had expired since being opened as indicated by the manufacturer's instructions. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. The findings were: During an observation and interview on 08/05/2025 at 9:04 AM the nurse medication cart #3 used for halls 300 and 400 was inspected with RN A present. There was one insulin pen that had an open date of 06/17/2025. RN A said that insulin pen should have been removed from the cart as it had expired since they were good for thirty days only. RN A said she worked at the facility as needed so she was not at the facility every day. RN A said as far as she knew it was each nurse's responsibility to check the insulins in their cart. RN A said she did not notice that the insulin pen had already expired when she took over the nurse's medication cart. RN A said if an expired insulin was used it might not produce the desired effects. During an observation and interview on 08/05/2025 at 9:14 AM the nurse medication cart #1 used for hall 100 was inspected with LVN B present. There was one insulin pen with an open date of 06/25/2025. LVN B said the insulin pen should have been removed since it had expired. LVN B said it was each nurse's responsibility to check their nurse's medication cart and inspect it for expired medications. LVN B said if a resident received an expired medication that it might not cause the desired effect as it was intended for. During an observation and interview on 08/05/2025 at 9:26 AM the nurse medication cart #2 used for hall 200 was inspected with LVN C present. There was one insulin vial which had been opened but did not have an open date written on it. LVN C said she had not noticed that the vial did not have an open date on it. LVN C said as far as she knew it was each nurse's responsibility to monitor their carts for undated or expired insulin pens and vials. LVN C said if the insulin vial was not dated then they would not know when the insulin would expire as they were good for 30 days after opening. During an interview on 08/07/2025 at 4:34 PM the DON said the expectation was for nursing staff to date the insulin pen or vial after they opened it or else how could they tell when the insulin expired. The DON said once the insulin container was opened they were usually good for 28 to 30 days. The DON said that the expectation was for nursing staff to discard any insulin pens that had expired. The DON said if insulin that had expired was used then it could lead to adverse effects and not be as effective. The DON said it basically was each nurse's responsibility to inspect their medication cart for any expired or undated medications and discard them. The DON believed the failure occurred because the nursing staff failed to inspect their medication carts. During an interview on 08/07/2025 at 4:54 PM the Administrator said the nursing staff should have dated the insulin once they opened it and discarded the expired one. The Administrator said the nurses were expected to inspect their medication carts and remove any expired or non-dated insulins. The Administrator said if an expired insulin was administered then it might not be as effective. Record review of the facility document titled Insulin pen use and dated 4/1/15 indicated in part: Storage instructions. Once you take the insulin pen out of cool storage you can use it for up to 28 days. Ensure that the pen is dated when placed into use. During this time it can be safely kept at room temperature up to 86 degrees Fahrenheit. Do not use it after this time.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #7) of 3 residents reviewed for infection control. LVN D failed to use PPE when she administered Resident #7's medication via his IV central line (A central line is a catheter placed into a large vein. A central line provides access to a person's blood supply, which allows the patient to receive medications, fluids or additional blood). This failure could place residents at risk for cross contamination and the spread of infection. Finding include: Record review of Resident #7's admission record dated 08/07/2025 indicated he was admitted to the facility on [DATE] with diabetes with a foot ulcer. He was [AGE] years of age. Record review of Resident #7's care plan dated 04/22/2025 indicated in part: Focus: Resident is on enhanced barrier precautions. Goal: There will not be any transmission of infection from or to the resident. Interventions: Gloves and gown should be donned if any of the following activities are to occur: wound care, enteral feeding care, catheter care or other high-contact activity. Record review of Resident #7's MDS assessment dated [DATE] indicated in part: Does this resident have one or more unhealed pressure ulcers/injuries? Yes. Special Treatments, Procedures, and Programs - IV Medications. Record review of Resident #7's order summary report dated 08/07/2025 indicated in part: Flush IV line with 10 ml of normal saline before and after medication. Aztreonam (antibiotic) Injection Solution Reconstituted 1 GM. Use 1 application intravenously every 8 hours for right heel wound infection for 4 Weeks. Order date 07/28/2025. During an observation on 08/06/2025 at 4:14 PM LVN E administered Resident #7's medication (Aztreonam) via his IV central line. LVN E entered the resident's room, sanitized her hands and put on a pair of gloves. LVN E then took a syringe that contained normal saline fluid and connected it to the IV central line and flushed it. LVN E then connected the antibiotic medication to resident #7's IV central line. LVN E then removed her gloves and was done with the administration. LVN E only wore gloves and not a gown. During an observation and interview on 08/06/2025 at 4:30 PM there was a document posted outside Resident #7's door that indicated the resident was on EBP precautions. The document indicated Enhanced barrier precautions. Providers and staff must also wear gloves and a gown for the following high contact resident care activities - device care or use - central line. LVN E was asked if she was supposed to have used a gown during Resident #7's medication administration, LVN E said she was not sure if she had to and did not recall if she had seen other staff use the gown during medication administration via the IV central line. LVN E said she thought that the reason Resident #7 was on EBP precautions was because he had a pressure sore and PPE had to be worn when wound care was performed. During an interview on 08/07/2025 at 4:32 PM the DON said the expectation was for nursing staff to use PPE when assisting Resident #7 with his central line. The DON said the nurse that assisted Resident #7 should have known she had to use PPE but that the nurse probably got nervous and forgot. The DON said if the nurse did not wear PPE as indicated then it could lead to the resident being exposed to infections. During an interview on 08/07/2025 at 4:50 PM the Administrator said the nursing staff should have worn PPE when they assisted a resident on EBP. The Administrator said if staff did not wear PPE, then it could possibly lead to the spread of infections. Record review of the facility's undated policy titled Enhanced Barrier Precautions indicated in part: Multidrug-resistant organisms (MDROs) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBPs) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employ targeted gown and glove using high contact resident care activities. EBP are indicated for residents with any of the following: Indwelling medical device examples include central lines. Record review of the facility's policy titled Infection control plan and dated 03/2024 indicated in part: Infection control - The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it, investigates, controls and prevents infections in the facility. Decides what procedures, such as isolation, should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections.</p>		