

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Deerings Nursing and Rehabilitation LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N County Rd West Odessa, TX 79763	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on interview and record review, the facility failed to ensure residents were free from abuse for 3 of 6 residents (Residents #1, #2, #3) reviewed for resident abuse. This was determined to be past noncompliance due to the facility having implemented actions that corrected the non compliance to the beginning of the inspection. The facility failed to prevent verbal abuse against Resident #3 by LVN B. The facility failed to prevent verbal abuse against Resident #1 by the dietary manager. The facility failed to prevent verbal abuse against Resident #2 by CNA A. These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress. These failures could place residents at risk of physical harm, mental anguish, and/or emotional distress. This was determined to be past noncompliance due to the facility having implemented actions that corrected the non compliance to the beginning of the inspection. The findings were: Review of Resident #3's Admission Record dated 2/14/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included anxiety disorder, Intermittent explosive disorder (a mental and behavioral disorder characterized by explosive outbursts of anger or violence, often to the point of rage that are disproportionate to the situation at hand), bipolar disorder (mood swings of highs and lows), and chronic pain syndrome. Review of Resident #3's Quarterly MDS assessment dated [DATE] revealed he scored an 8 on his mental status exam (indicating moderate cognitive impairment), he had verbal behaviors directed toward others and behaviors not directed toward others on a daily basis, he usually understood others and his vision was highly impaired. He used a walker and a wheelchair for mobility, and he required moderate assistance with personal hygiene and was able to toilet himself. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #3's care plan reflected: Resident has potential to demonstrate verbally abusive behaviors. r/t intermittent explosive behaviors. Goal: Resident will verbalize understanding of need to control, verbally abusive behavior through the review date. Date Initiated: 09/06/2024 revision on: 09/18/2024 Interventions included: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document date Initiated: 09/06/2024, flu with psych services as indicated date Initiated 01/07/2025. Give resident as many choices as possible about care and activities date Initiated: 09/06/2024, Notify the charge nurse of any abusive behaviors Date Initiated: 09/06/2024. When the resident becomes agitated Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation. During an interview on 2/11/25 at 6:07 PM to 6:26 PM, The visitor stated while she was at the facility on January 13, 2025, she witnessed LVN B verbally abuse Resident #3. Resident #3 was standing at the back of nurse's station when LVN B rose from her chair. She came from behind the nurse's station yelling at the resident and told him not to talk to the staff that way. The visitor stated she was sitting across from the nurse's station on the couch against the west wall. She stated she did not hear Resident #3 say anything, but she could tell he had spoken to the staff. She stated she could hear LVN B very clearly when she yelled at him that he had been to the bathroom earlier and pointed her finger in his face and told him to go down the hall to the bathroom where he been earlier. The visitor stated she heard Resident #3 say he could not remember where he had gone to the bathroom. He stated he needed to go to the bathroom again. The visitor stated LVN continued to scold him as she walked him to the shower room. The resident was apologetic and hanging his head down and told her he just needed to go to the bathroom, and he could not go in his room because the toilet was leaking. She took him in to the shower room and immediately returned to the nurse's station. The visitor stated she heard someone tell the resident that they were going to move him to another room because the toilet in his room was not working. She stated she approached the nurse's station and told LVN B that she had spoken to Resident #3 in an abusive manner. She stated LVN B stated, I was redirecting him, and it was not abuse. Go ahead and report me if you want to. The visitor stated she reported the incident to the Interim administrator the next day and filed a report with the HHSC complaint hotline . In an interview with CNA C at 5:00 PM on 2/11/25 she stated she had been inserviced on abuse and neglect. She stated she had not witnessed any staff member treat a resident in an abusive manner. She stated she loved the residents and would report abuse immediately to the administrator. She stated abuse could be verbal, physical, or mental. In an interview with CNA D on 2/13/25 at 4:00 PM she stated she did not hear an altercation between LVN B and Resident #3 on 1/13/25. She stated she had never heard seen any staff member speak to a resident in an abusive manner. She stated she was last inserviced on abuse and neglect on 1/23/25 . She stated abuse could be verbal, physical, or mental. Interview with CNA E at 12:00 PM on 2/13/25 she stated she knew that abuse could be verbal, physical, or mental. She stated abuse could be withholding care from a resident. She stated she had never witnessed a coworker be abusive toward a resident and that she would report immediately to the administrator or DON. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/14/25 at 10:00 AM, Resident #3 stated he did not remember any staff member speaking to him in an abusive manner. He stated he felt safe in the facility and kept repeating he did not want to get anyone in trouble. During an interview on 02/13/25 at 4:45 PM, the Administrator who was also the facility abuse coordinator stated LVN B was terminated at the conclusion of her investigation due to violating resident rights and unbecoming conduct for a company employee. She stated she felt the 3 incidents of alleged abuse had occurred because the facility several different administrators in the past year and staff were not trained properly. She stated the Administrator, the DON and the Human Resource manager were responsible for training employees on abuse and neglect. During an interview on 2/14/25 at 1:00 PM the Corporate Regional manager of the facility stated she monitors the facility closely to ensure residents are free from abuse and neglect. She said her monitoring includes reviewing all incidents that were reported by the facility, visiting with the ombudsman and residents of the facility and conduct onsite visits with the facility staff to ensure that the residents were protected from abuse and neglect. Record review of Resident #1's Face Sheet (Admission Record) dated 2/14/25 indicated a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's medical history included adult-onset diabetes (a condition in which there is too much sugar in the blood), end stage renal disease (a condition in which the kidneys cannot filter wastes from the blood), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), dependence on renal dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys are no longer able to do so), protein calorie malnutrition (a nutritional state in which reduced availability of nutrients leads to changes in body composition and describes a condition that results in mild to severe undernutrition). Record review of Resident #1's Optional State MDS assessment dated [DATE] reflected the resident had a BIMS score of 15 which indicated she was cognitively intact. The MDS assessment indicated Resident #1 displayed no behaviors. The assessment also indicated Resident #1 used a wheelchair for mobility, was independent with transfers and bed mobility, eating and did not have significant wt loss. Record review of Resident # 1's care plan reflected a problem which was initiated on 1/24/25. It stated that Resident #1 had a history of making false accusations. Interventions included were: Have a witness Present when giving resident money and remind resident in a calm manner. There were no other interventions listed and both were initiated on 1/24/25. During an interview on 2/13/25 at 10:58 AM, the Activity Director stated she was in the dining room on 1/23/25 at 2:00 PM when Resident #1 had returned from dialysis. She stated Resident #1 was upset and angry because her lunch tray had not been saved for her until she returned from dialysis. She stated Resident #1 was cursing and the Dietary Manager confronted Resident #1 in the Activity Directors doorway of her office and asked Resident #1 What the F-K is your problem screaming at my staff? The Activity Director stated the Dietary manager also told Resident #1 she knew Resident #1 had thrown the staff under the bus by complaining to the Ombudsman about the dietary staff. The Activity Director stated Resident #1 immediately said: I'm sorry, I'm sorry to the Dietary Manager, and the Dietary manager told the Resident that she needed to apologize to her staff. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/14/25 at 11:00 AM, Resident #1 stated she vaguely remembered the incident with the Dietary Manager. Resident #1 said she remembered that her and the Dietary Manager were both angry, but she stated sometimes she did not remember things well because of her dialysis and kidney disease. She stated she remembered she was so upset because the dietary staff did not save her anything to eat. He stated that the dietary manager had been terminated due to the incident and she felt safe in the facility at the time of the interview. She stated if she had concerns with abuse to herself or other residents, she would report it to the administrator or the DON. Attempted to interview the Dietary Manager by phone on 2/14/25 at 11:30 AM but was unable to reach her by phone or leave a message. During an interview on 2/13/25 at 3:45 PM the administrator stated the Activity Director did not report to witnessing abuse or had suspicions of abuse toward Resident #1 by the Dietary Manager when she witnessed the confrontation between the Dietary Manager and Resident #1. She stated her expectation was any suspicion of abuse or allegations of abuse be reported to her immediately. She stated an Inservice on abuse and neglect was given to all staff on 1/23/25 and again on 1/24/25. All staff attended. Review of Resident #2's Admission Record dated 2/13/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included major depressive disorder recurrent (a common condition and serious mental health condition that is characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), psychotic disorder (a mental illness characterized by a disconnection from reality), dementia with behavioral disorder (a general term for loss of memory, language, problem-solving, and other thinking abilities that are severe enough with daily life and inappropriate social interactions) , and pain in unspecified joint. Review of Resident #2's Annual MDS assessment dated [DATE] revealed he scored a 3 on his mental status exam (indicating severe cognitive impairment), he had verbal behaviors directed toward others 1-3 days during the 14 days look back period, moderate assistance with eating, was dependent with adl's, and used a wheelchair for mobility. Record review of Resident # 2's care plan reflected a problem: Resident #2 yells out, cursing at staff. He takes medication for intermittent explosive disorder. Goal resident #2 will have less than 20 episodes a day of yelling out. Interventions included: Resident #2 will be redirected when yelling, Resident #2 o Resident has been noted with yelling out 'help, help'. When doing so please provide resident with polite encouragement on using call-light appropriately to not disturb other residents. Dated revised 2/15/24 and initiated on 2/15/24. A record review of inservices reflected an inservice on 1/13/25 on the facility's abuse and neglect policy and procedure and was attended by CNA A. An inservice on abuse and neglect was also held on 1/15/25 after the incident with CNA A and attended by 35 facility staff including CNA's, Nurses, Dietary staff, H/R Manager, housekeeping staff, Business Office Manager and the Activity director. Record review of the facility investigation 5-day report revealed the incident occurred on 1/15/25 at 5:00 PM and was reported to HHSC at 9:15 PM on 1/15/25. The perpetrator was immediately suspended and terminated at the conclusion of the investigation. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/13/25 at 2:30 PM, the HR Manager said on 1/15/25 at 5:30 PM, she was in her office and heard someone yelling at Resident # 2 to Shut up! She stated she heard it a second time as she was getting up from her desk to see what was going on. She stated she saw CNA A in the hallway and heard her scream loudly at Resident #2. She stated she immediately reported it to the AIT who reported it to the interim administrator. During an interview on 2/13/25 at 3:45 PM, the administrator stated she had zero tolerance for abuse. She stated an Inservice on abuse and neglect was completed on 1/15/25 with all staff and CNA A was terminated. She stated the dietary manager was suspended immediately when the allegation of abuse was reported, and she was fired at the completion of her investigation which revealed the dietary manager did confront the resident and speak to her in a disrespectful manner and violated the corporate code of conduct. Review of the facility policy titled Abuse/Neglect dated 3/29/18, revealed, in part: Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse is any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on interview, and record review the facility failed to ensure all alleged violations involving abuse are reported immediately to the Administrator of the facility for 1 of 6 residents (Resident #1) reviewed for abuse. 1. The Activity director failed to immediately report her suspicions of abuse when she heard the Dietary Manager use profanity directed toward Resident # 1. This failure could affect any resident and contribute to further abuse or neglect This was determined to be past noncompliance due to the facility having implemented actions that corrected the non compliance to the beginning of the inspection. Findings included: Review of facility policy titled Abuse/Neglect dated revised 9/9/24, revealed, in part: Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse is any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Record review of Resident #1's Face Sheet (Admission Record) dated 2/14/25 indicated a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's medical history included adult-onset diabetes (a condition in which there is too much sugar in the blood), end stage renal disease (a condition in which the kidneys cannot filter wastes from the blood), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), dependence on renal dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys are no longer able to do so), protein calorie malnutrition (a nutritional state in which reduced availability of nutrients leads to changes in body composition and describes a condition that results in mild to severe undernutrition). Record review of Resident #1's Optional State MDS assessment dated [DATE] reflected the resident had a BIMS score of 15 which indicated she was cognitively intact. The MDS assessment indicated Resident #1 displayed no behaviors. The assessment also indicated Resident #1 used a wheelchair for mobility, was independent with transfers and bed mobility, eating and did not have significant wt loss. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 1's care plan reflected a problem which was initiated on 1/24/25. It stated that Resident #1 had a history of making false accusations. Interventions included were: Have a witness Present when giving resident money and remind resident in a calm manner. There were no other interventions listed and both were initiated on 1/24/25. Record review of the facility's investigation worksheet dated received on 1/24/25 and the provider 5-day and investigation report dated 1/30/25 documented the incident occurred on 1/22/25 at 2:00 PM and was reported to regulatory services by the Regional Nurse on 1/23/25. During an interview on 2/13/25 at 10:58 AM, the Activity Director stated she was in the dining room on 1/23/25 at 2:00 PM. She stated resident #1 had returned from dialysis and had come into the dining room. She stated Resident #1 was upset and angry because her lunch tray had not been saved for her until she returned from dialysis. She stated Resident #1 was cursing. The Dietary Manager confronted Resident #1 in the Activity Directors office doorway and asked her: What the F-K is your problem screaming at my staff? The Activity Director stated the Dietary manager told Resident #1 she knew Resident # 1 had thrown the staff under the bus by complaining to the Ombudsman about them not doing their jobs. The Activity Director stated Resident #1 immediately said: I'm sorry, I'm sorry to the Dietary Manager, The Dietary manager told Resident #1 that she needed to apologize to her staff for cursing. The Activity Director stated she did not report it to the Administrator until 1/24/25. She stated she stated she did not realize she should have reported the incident immediately. She stated she started in July of 2024, and she had an in-service on abuse during orientation, but she did not remember anything about how soon it should be reported. She stated she had been inserviced and counseled after the incident by the interim administrator. During an interview on 2/14/25 at 11:00 AM, Resident #1 stated she vaguely remembered the incident with the Dietary Manager. Resident #1 said she remembered that she and the Dietary Manager were both angry, but she stated sometimes she did not remember things well because of her dialysis and kidney disease. She stated she remembered she was so upset because the dietary staff did not save her anything to eat. She stated that the dietary manager had been terminated due to the incident and she felt safe in the facility at the time of the interview. She stated she stated if she had concerns with abuse to herself or other residents, she would report it to the administrator or the DON. Attempted to interview the Dietary Manager by phone on 2/14/25 at 11:30 AM but was unable to reach her by phone or leave a message. During an interview on 2/13/24 at 3:45 PM, the administrator stated the Activity Director did not report witnessing abuse or had suspicions of abuse toward Resident #1 by the Dietary Manager when she witnessed the confrontation between the Dietary Manage and Resident #1. She stated her expectation was that suspicion of abuse or allegations of abuse be reported to her immediately. She stated an Inservice on abuse and neglect, and Resident Rights had been started on 1/23/25 and 1/24/25 and completed by all staff on immediate reporting of allegations of suspected abuse or neglect and resident rights. She stated it was her responsibility to monitor complaints and concerns by residents and ensure the facility was doing all that was within their control to prevent occurrences of abuse and neglect. She stated the dietary manager was suspended immediately when she when the allegation of abuse was reported, and she was fired at the completion of her investigation which revealed the dietary manager did confront the resident and speak to her in a disrespectful manner and violated the corporate code of conduct.		