

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 06/13/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed treat each resident with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for two of five residents (Residents #5 and #7) reviewed for treatment with respect and dignity.</p> <p>CNA A and HA B stood while feeding Residents # 5 and #7.</p> <p>RN C was on her phone while monitoring the dining room with residents present.</p> <p>HA B was texting while feeding Resident #5.</p> <p>This failure placed residents at risk of feeling embarrassed, infantilized, dehumanized, or stigmatized due to their need for assisted dining.</p> <p>Findings included:</p> <p>Record review of Resident #5's admission Record, dated 6/13/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (progressive neurological disorder causing tremors, stiffness, and slow movement).</p> <p>Record review of Resident #5's Annual MDS Assessment, dated 3/27/25, revealed: (the updated MDS was in progress)</p> <p>He had a mental status score of 3 of 15 (indicating severe cognitive impairment),</p> <p>He needed supervision while eating.</p> <p>Record review of Resident #7's admission Record, dated 6/13/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a progressive central nervous system disease affecting the brain and spinal cord causing muscle weakness, balance issues and cognitive issues).</p> <p>Record review of Resident #7's Quarterly MDS Assessment, dated 4/10/25, revealed:</p> <p>He had a mental status score of 10 of 15 (indicating moderate cognitive impairment)</p> <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>He needed substantial or maximal assistance with eating.</p> <p>Record review of Resident #7's care plan, updated 2/15/24, revealed:</p> <p>Resident #7 had an ADL Self Care Performance Deficit. Identified interventions included: The resident required to be fed.</p> <p>Observation on 6/12/25 at beginning at 12:07 p.m. of the lunch meal revealed: there were 27 residents present.</p> <p>At 12:08 p.m. Resident #7 was served a meal of a sandwich; CNA A fed him standing up. There was a chair immediately behind CNA A, she kicked the chair out of way when CNA walked around Resident #7 to get extra napkins.</p> <p>At 12:23 p.m., HA B stood while feeding Resident #5. HA B had no interaction with Resident #5. She held a roll up to Resident #5's mouth while Resident #5 took bite after continuous bite. Eventually the Administrator promoted HA B to sit. After sitting, HA B's phone went off and she held it under the table while answering it. HA B got up and walked away from Resident #5 to answer the phone without saying a word to him and returned.</p> <p>An observation at 12:44 p.m. on 6/12/25 revealed RN C stood to the side of the room scrolling on her phone while she was supposed to be monitoring the dining room.</p> <p>Interview on 6/12/25 at 1:09 p.m. CNA A stated she worked at the facility off and on for three years, but this was her second day back. CNA A stated she was trained to sit while feeding residents and talk to them at eye level and talk to them so you could if there were any choking issues instead of standing like I was and it's more comfortable for the residents. CNA A stated she usually sat while feeding residents but she just wanted to stand on 6/12/25.</p> <p>Observation on 6/12/25 at 3:23 p.m. revealed RN C behind the nurse's station scrolling on social media.</p> <p>Interview on 6/12/25 at 5:01 p.m. HA B stated she was trained to feed residents sitting down. HA B did not know the reason. HA B said the reason she stood was because it was more work to sit to feed Resident #5. HA B said she did not talk to Resident #5 because her English was very limited.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/12/25 at 5:58 p.m. the DON stated her expectation for feeding residents was that aides sat down at eye level because it was patient centered care. The DON said the staff were not to have phones out, staff were to have all their attention on the resident. The DON stated she monitored for that when she was in the dining room. The DON stated she told CNA A to sit down at lunch. The DON said she felt the aides were not giving the residents the attention they needed when they were not sitting. The DON stated giving unrestricted bites while the staff was on the phone was not ok because residents needed to be taking one bite at a time. The DON stated nurses were responsible for monitoring for cell phone use while in the dining room. The DON stated she had in-serviced staff on phone use and every time she caught staff on phones she did an in-service. The DON said she did not notice RN C on the phone during lunch and said she was not doing a good job of monitoring if she was on the phone. The DON stated nurses were allowed to be on the phone if they were trying to get a hold of the doctor. The DON stated they were not supposed to be on social media because that took away from their job.</p> <p>Interview on 6/12/25 at 6:39 p.m. the Regional RN stated the corporate expectation was staff sit down and assist residents who needed help eating. The Regional RN said this was supposed to be monitored by the charge nurse and administrative staff routinely. The Regional RN stated routinely meant any time they passed by, there was no set number of times the staff needed to check. The Regional RN said it was in the employee handbook to not be on the phone. The Regional RN stated they told staff to step outside if they needed to take a phone call and it was not ok to be at the table and on the phone at the same time because it sent the message the phone was more important. The Regional RN said he would be upset if he was the resident.</p> <p>Interview on 6/13/25 at 1:11 p.m. a random resident interview stated they were the only person who noticed staff were on their phones all the time. The resident said they were afraid to approach staff when staff were on their phone because they did not want to interrupt the staff and ask for what the resident needed.</p> <p>Record review of the facility's Guidelines for Dining Room Etiquette, undated, revealed:</p> <p>Do not carry on conversations with coworkers that do not pertain to residents and their dining experience, do not shout across the dining room or elevate your voice. Do not use a cell phone while assisting residents in the dining room. Try to keep the dining room [NAME] and minimize noise.</p> <p>If you assist residents by feeding them, make sure that you are sitting at eye level with them, not standing over them.</p> <p>Record review of the Employee Handbook, undated, revealed:</p> <p>Personal Communication devices: use of personal communication devices during scheduled work hours is not permitted at the facility.</p> <p>Record review of the facility's policy and procedure on Resident's Rights, revised 11/28/16, revealed.</p> <p>The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility, including:</p> <p>(continued on next page)</p>		

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