STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675317	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerings Nursing and Rehabilitation, LP	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 record review and interviews the facility failed to ensure that 1 (Resident #1) of 5 residents reviewed for transfer or discharge had the required documentation in the resident's medical record made by the physician for a safe and effective transition of care. The facility discharged Resident #1 on 07/25/2025 without conducting a safe discharge as indicated in the facility's policy and provide an effective transition of care. This failure could put residents at risk for inappropriate discharge from the facility and cause psychological harm due to feelings of anger and sadness.The findings included: Record review of Resident #1's admission record dated 10/07/2025 revealed he was admitted to the facility on [DATE] with diagnoses of alcohol dependence with withdrawal, depression and weakness. He was [AGE] years of age and was his own responsible party. Record review of the current care plan for Resident #1, last reviewed/revised: 06/13/2025, revealed The resident has a behavior problem r/t cognitive deficit as evidence by he was smoking in his room, resident is buying alcohol beverages thru door dash and drinking alcohol (consumption) in the building that could interfere with his medication and create health problems such as falls with fractures including fall resulting death. Resident will not smoke in his room x 90 days. Resident will not consume alcohol beverages in the building x 90 days. Educate resident on health consequences of alcohol consumption. Notify MD/FNP of resident's alcohol consumption. Offer AA services to resident. Sign a negotiated agreement with resident. Record review of Resident #1's discharge MDS assessment dated [DATE] revealed: BIMS totaled 6 indicating resident had severe impairment. Urinary continence was occasionally incontinent and bowel continence was always continent. Mobility - used manual wheelchair. Review of Resident #1's progress notes dated 05/06/2025 revealed Resident reported not being happy at the nursing home but understands why he needs to be here. D/C plan to be discussed with the interdisciplinary team. Review of Resident #1's progress notes dated 06/28/2025 revealed Doctor with resident. Instructed to stop drinking alcohol. Asked if he experiences anxiety. Resident stated yes. New order received. Review of Resident #1's progress notes dated 07/25/2025 at 2:41 am revealed: Resident previous Administrator here and resident [1] loaded into car with belongings. All medications and instructions sent with [previous] Administrator. Now out of the building. Author: LVN A. During a telephone interview on 11/07/2025 at 2:08 pm, the previous Administrator said Resident #1 was being non-compliant with the rules of him not listening to stop bringing in alcohol into the building, said the resident continued to do that and placed other resident's at risk in case they got a hold of the alcohol. The Previous Administrator said there had been a 30-day discharge given to Resident #1 but did not recall if they had made the Ombudsman aware. He said there should be evidence of that letter somewhere in his record. He said Resident #1 agreed to go to the other facility which was a type of group home and the resident's family member was also okay with that. The Previous Administrator said they had not just given the resident 2 hours to get ready and then taken him out of the facility. He said they had not had a meeting regarding the discharge. During a telephone interview on 11/07/2025 at 3:15pm - Attempted to reach Resident #1 via his phone on several occasions and there was no answer. The resident's phone was not set up to leave messages. During a telephone interview on 11/07/2025 at 3:20pm with Resident #1's family member, she said that she was not sure if the facility was able to do that, meaning to discharge him. The family member said she felt she had no say regarding that since Resident #1 was his own responsible party. The family member said she was not sure if the facility could just discharge someone. The family member was made aware of surveyor reaching out to Resident #1 but he did not answer his phone. The family member said the resident was very deaf and for surveyor to consider texting him. The family member said she knew Resident #1 had been discharged to a facility out of town, knew what facility it was and also was aware that Resident #1 was currently residing there. During a telephone interview on 11/07/2025 at 3:40 pm Resident #1's doctor stated that he recalled having a talk with Resident #1 regarding him drinking alcohol and it being mixed with his medications. The doctor said apparently the resident would continue to be non-compliant. The doctor said if Resident #1 continued to mix the alcohol with his medication that could lead to a bad effect. The doctor said he did not recall signing a discharge notice or letter regarding the resident's discharge from the facility. The physician said he did not recall having some kind of meeting regarding Resident #1's discharge plans. During an interview on 11/07/2025 at 3:52 pm with t he facility he said he did not recall them issuing Resident #1 a 30-day notice or notifying the Ombudsman regarding the discharge. The RCN said he would have been aware if they had issued one because that meant they would