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	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerings Nursing and Rehabilitation	1020 North County Road 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 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. **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 7 residents (Resident #1) reviewed for accidents. The facility failed to complete and a two-person gait belt transfer when CNA A and CNA B hooked their arms underneath Resident #1's arms and picked her up from the floor. The facility failed to notify LVN C when CNA A and CNA B found Resident #1 on the floor. This failure could place residents at risk of inadequate supervision and preventable injuries. Findings included: Record review of Resident #1's admission Record, dated 6/24/26, revealed s a [AGE] year-old male, admitted [DATE], with diagnoses including stroke, depression, anxiety, and aphasia (difficulty communicating). Record review of Resident #1's Significant Change MDS Assessment, dated 6/10/26, revealed:He had a BIMS score of 6 of 15 (indicating severe cognitive impairment).He needed substantial assistance with transfers.There were no documented falls on the MDS. Record review of Resident #1's Care Plan Report, last updated 1/16/26, revealed:Problem: Resident is at risk for falls related to cognitive deficit, poor safety awareness. Goal: Resident will not sustain serious injury through the review date. Interventions included: anticipate and meet the resident's needs; may have anti-rollback device on wheelchair; may have non-slip grip to wheelchair seat. There was no indication of how to transfer Resident #1. During an observation on 6/24/26 at 11:29 a.m., Resident #1 was sitting on the floor in the doorway of his room. CNA A asked why Resident #1 was on the floor and he said he needed to get something. CNA A said this was why he needed to use the call light. CNA A and CNA B then stood on either side of Resident #1, hooked their (CNA A and CNA B) arms under Resident #1's arms, pulled Resident #1 up, and then placed Resident #1 in the wheelchair. During an interview on 6/24/26 at 11:45 a.m., the DON said when a resident fell, she expected staff to do an incident/accident report. The DON stated if an aide found a resident on the ground, she expected the aide to get the nurse, make sure the resident was safe until the nurse assessed for vital signs, pain, or injuries. The DON said she expected the staff to ask the resident why, and how, they fell, if they remembered. They DON said she expected staff to notify her, the resident's doctor, and start Neurological checks (a rapid, focused evaluation used by healthcare providers to assess a patient's nervous system functioning and monitor for changes in brain or nerve activity) if necessary. The DON stated Resident #1 had a history of stroke and was very impulsive and needed a lot of help with ADLs and he had no safety awareness. The DON said Resident #1 wanted to do a lot of things by himself and needed a lot of redirection. The DON stated Resident #1's last fall had been a while. The DON stated a fall would be from the wheelchair to the floor. The DON stated Resident #1 had a low bed with a mat because he would put himself on the floor and crawl around. The DON said if Resident #1 was found on the floor she expected the staff to use a gait belt to assist in getting Resident #1 off the floor. During an interview on 6/24/26 at 12:32 p.m., LVN C stated that when a resident fell, she assessed the vital signs and looked for injuries. LVN C said she looked for skin tears or bones protruding. LVN C said she asked for soreness or complaints of hurting and then she would get orders for an x-ray. LVN C said she liked to help the aides get the residents off the floor if they fell. LVN C (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she transferred residents from the floor to the wheelchair and then the bed so she could do a full assessment. Then she would notify the doctor, the DON, the Responsible Party, and hospice if necessary. LVN C said after assessments and notifications, she was looking to see if fall mat was in place. LVN C stated most of the falls on her hall were the residents trying to get into the chair or get something out of the closet and leaned too far forward. LVN C said she got residents off the floor by hooking her arms under the resident's arms and transferred them. LVN C stated no one told her Resident #1 fell 6/24/26 in her room. LVN C stated she expected the aides to tell her when a resident fell and she had two aides. LVN C left to do an assessment on Resident #1. During an interview and observation on 6/24/26 at 12:45 p.m., Resident #1 in his wheelchair holding his arm out. LVN C sprayed disinfectant on his arm and Resident #1 yelled. LVN C stated she monitored for falls by making sure fall prevention measures were in place. LVN C said the staff tried to keep their eye on the high-risk residents and if the staff saw the high-risk residents going into their room, the staff tried to follow them and transfer the high-risk resident to bed. LVN C said Resident #1 liked to crawl out of bed a lot. LVN C said if the wheelchair was immediately behind Resident #1 it was a fall. During an interview on 6/25/26 at 1:48 p.m., PT D stated the correct way to pick up a resident was to first let the nurse know to assess; have two people; place a gait belt on the person; stand side-by-side to pick up the resident. PT D said the staff could do front and back or side to side. PT D said hooking under the arms could cause shoulder dislocation. PT D said she did help with in-services on transfers approximately quarterly. PT D said staff should know how to do a two-person transfer. PT D said she saw some of the staff with gait belts. PT D said she did not monitor the back halls very much. PT D said she monitored the front halls for gait belts. PT D said most of the residents who needed gait belts were on the back two halls. During an interview on 6/25/26 at 1:26 p.m., the DON stated the expectation was for the staff put the gait belt under the resident's chest, put their arm under the resident's arms and grab the back of the gait belt. The DON stated the staff could grab one-handed if it was two-person transfer, as long as there were two hands on the gait belt it was ok. The DON said she did expect gait belts to be used. The DON stated she monitored for gait belt use because she was out on the floor. The DON said she expected the aides to have a gait belt on their person. The DON said aides had a yearly evaluation on transfers. After being informed of the 6/24/26 observation, the DON and Administrator both said the transfer was not completed correctly and the fall was not handled correctly. The DON said she did not know of any incident where Resident #1 went from the wheelchair to the floor purposely. The Administrator stated consequences of an improper transfer could be dislocation or injury and the gait belt really there for support. Record review of the facility's undated policy and procedure titled, Moving a Resident Bed to Chair/Chair to Bed, indicated, : The purpose of this procedure is 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: Note: 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 persons (one on each side) grasp the gait belt and gently stand and turn the resident and sit him or her in the chair. Support the resident by placing a gait belt around the resident's waist for you to hold and steady the resident. Record review of the undated CNA Proficiency check list documented one-person and two-person transfers were both transfers that were expected to be done satisfactorily. Record review of the facility's undated policy and procedure titled, Fall Policy revealed: Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. In instances where fall risk measures do not prevent a fall, the resident will be assessed immediately for injury. Vital signs and first aid measures will be completed immediately. The Charge Nurse will notify the attending physician and family member as soon as possible after the resident has been stabilized. Record review of in-service, dated 4/20/26, revealed: If you find a resident on the floor, they a nurse assessment before being picked up off the floor. Neither CNA A nor CNA B attended the in-service.