

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 03/20/2025
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48593 Based on observation, interview and record review the facility failed to ensure each resident was provided food prepared in a form designed to meet individual needs for 1 of 1 resident (Residents #213) reviewed for pureed diets. The facility failed to prepare the pureed diet to the consistency required for Resident #213. This failure could place residents at risk of not having nutritional needs met by consuming foods that could cause choking and decreased meal intakes. Findings include: Record review of Resident #213's facility face sheet, dated March 20, 2025 revealed Resident #213 was a [AGE] year-old female admitted to the facility on [DATE]. Her Medical diagnoses included cerebral infarction (lack of blood flow to an area of the brain, leading to brain cell death), dementia, type II diabetes mellitus. Record review of Resident #213's admission MDS (Minimum Data Set) assessment, dated March 8, 2025, revealed resident was to have a mechanically altered diet. Resident's Brief Interview for Mental Status was not conducted as the resident is rarely or never understood. Record review of Resident #213's care plan, dated March 5, 2025, revealed an intervention of offer a diet as ordered by the physician. Record review of Resident #213's physician order summary report, dated March 20, 2025 revealed a diet order of regular diet with pureed texture and nectar consistency fluids. Ordered initiated 03/19/2025. During an observation on 03/18/2025 at 11:50 am and 03/19/2025 at 11:45 am the puree tray was observed to be runny and water-like, and not a smooth, pudding-like consistency. During an interview with [NAME] G, who prepared the pureed tray, on 03 /19/25 at 12:00 PM she stated that she was trained by videos for puree texture. She stated that the food needs to be smooth. [NAME] G did not know the puree should have been thicker. (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dietitian on 3/20/2025 at 11:10 am she stated that the puree dishes should have a smooth pudding like consistency and should stay on the spoon when scooped and turned over. She stated that the kitchen can make the consistency thinner if it was ordered by a doctor, but it should not be runny or a water-like consistency. During an interview with the DM on 03/20/25 at 1:31 PM revealed that she was not checking the consistency of the puree but did have a communication sheet from the nursing staff to make the resident's puree thinner. The DM was unable to produce communication sheet. Record review of the facility's policy titled Consistency Modification dated 2012 revealed in part, 3. The desired consistency for blended foods is that of applesauce to mashed potatoes.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48593 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure food items in the facility's only dry storage were dated and sealed appropriately. 2. The facility failed to ensure food items in the facility's only walk in freezer were dated and stored appropriately. 3. The facility failed to ensure food items in the facility's only walk in refrigerator were thrown out after use by date, and ensure items were labeled and dated appropriately. 4. The facility failed to ensure personal food items were not stored in the facility's only walk in refrigerator. 5. The facility failed to ensure items were not stored on the ground of the dry food storage. 6. The facility failed to check temperatures of food items prior to serving food. These failures could place residents at risk for food-borne illness, and food contamination. Findings include: Observations of the facility's kitchen's only dry storage on 03/18/25 at 10:22 AM revealed the following items were not sealed or dated, items found stored on the floor of the dry food storage: - A stack of four tin containers which each had what appeared to be pie crust in them open and undated. - One box of thermal cups was found stored between two food racks on the ground. Observations of the facility's kitchen's only walk in fridge on 03/18/25 at 10:30AM revealed the following items were not dated or passed the use by date: - One bottle of sparkling water with no resident label. Staff was later seen drinking this drink. - A container labeled Potato Salad with a use by date of 03/16/2025 - A container labeled apple jelly: with a use by date of 03/16/2025 - A container with no label or date contained a bag with what appeared to be a red sauce. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A container with a label of strawberries with no use by date but an open date of 1/30/2025. Observations of the facility's kitchen's only walk in freezer on 03/18/25 at 10:40AM revealed the following items were not labeled, dated, or properly covered: - Three uncovered single serve containers of an orange frozen substance next to a container of Orange Flavored Sorbet Observation of lunch meal service on 3/18/2025 and 3/19/2025 revealed no temperatures were taken prior to serving meals. During an interview on 3/19/2025 at 12:30 pm with [NAME] G stated that she was unaware that she needed to take temperatures prior to serving food. [NAME] G stated that she checks the temperatures when cooking to ensure the food items were cooked to safe temperatures. During an interview on 03/20/25 at 1:31 PM with the DM, she stated she was unaware of the items not being stored properly in the dry food storage or refrigerator. The DM stated that she did remove the Orange Sorbet from the freezer when she saw that they were not covered. The DM stated she has tried to teach the staff that the walk-in fridge was not for personal use but the previous manager allowed it so it has been hard to break the habit. The DM stated the staff should be labeling everything that was opened with an open date and use by date. The DM stated that every item that was opened should be placed into a sealable container. The DM stated that the previous manager did not have the staff take temperatures prior to serving meals only when the items were cooked to ensure that items reached safe temperatures. Record review of the facility policy titled storage refrigerators dated 2012 stated in part 5. Food must be covered when stored, with a date label identifying what is in the container. Record review of the facility policy titled Dry storage and Supplies dated 2012 stated in part b. all food and supplies are to be stored six (6) inches above the floor on surfaces which facilitate thorough cleaning. And 4. Open packages of food are stored in closed container with tight covers and dated as to when opened. Record review of the facility policy titled Daily food temperature control dated 2012 stated in part We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the temperature log.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #57 and Resident #214) of 16 residents reviewed for infection prevention and control. The ADON failed to wear PPE when performing wound care for Resident #57 who was on EBP for an indwelling catheter and a Stage 3 pressure ulcer on his coccyx (area at the base of the spine). CNA A and NA B failed to wear PPE when providing incontinent care for Resident #214 who required EBP for a Stage 4 pressure ulcer to her sacrum (lower back between the hip bones). These failures could put residents at risk of acquiring infections, secondary infections, and communicable diseases. Findings include: Record review of Resident #57's facility face sheet, dated 3/19/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. His medical diagnoses included obstructive and reflux uropathy (condition where urine flow is blocked leading to backflow of urine into the kidneys) and stage 3 pressure ulcer to the coccyx. Record review of Resident #57's Admission MDS Assessment, dated 2/13/25, revealed one stage 3 pressure ulcer that was present on admission to the facility and the presence of an indwelling urinary catheter. Record review of Resident #57's care plan, initiated 2/11/25 and revised 3/18/25, revealed a focus that Resident #57 was on Enhanced Barrier Precautions (EBP) related to an open wound and indwelling catheter. During observation on 3/19/25 at 2:45 pm, the ADON failed to apply all required PPE - he only wore gloves - while performing wound care to the wound on Resident #57's coccyx in compliance with the facility's EBP policy. Record review of Resident #214's facility face sheet, dated 3/20/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her medical diagnoses included hepatic encephalopathy (brain dysfunction caused by liver dysfunction), hypertension (High blood pressure), pressure ulcer of sacral region stage 4, functional quadriplegia (complete immobility due to severe disability), Record review of Resident #214's admission MDS assessment, dated 3/7/25, revealed resident was dependent with incontinent care. Record review of Resident #214's care plan, dated 3/5/25, revealed a focus that Resident #214 was on enhanced barrier precautions related to open wound. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 3/18/25 at 4:23 PM of incontinent care for Resident #214 revealed CNA A and NA B did not apply the required personal protective equipment (PPE) - they wore gloves only - to comply with enhanced barrier precautions (EBP) as ordered. In an interview on 3/18/25 at 4:40 PM with CNA A and NA B both stated that they did not realize the resident had a wound and they were unaware they needed the EBP. In an interview on 3/19/25 at 3:00 pm the ADON stated that he was aware that Resident #57 was on EBP, and he forgot to apply PPE. He stated he had no excuse as the facility's infection preventionist and the person responsible for ensuring EBP was done properly, and that he just overlooked the PPE cart at the bedside. In an interview on 3/20/25 at 02:30 PM with the DON stated that EBP should be worn during high contact activities including incontinent care for residents who have wounds, extra lines, tubes or catheters. She stated that the ADON should have worn gloves and a gown during Resident #57's wound care and that CNA A and NA B should have worn gloves and gown during incontinent care. The DON stated that staff should hand sanitize or wash hands between glove changes. The DON stated that the staff should change gloves between clean and dirty tasks. Review of facility policy Enhanced Barrier Precautions dated 4/1/24 revealed, in part: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug resistant organisms) to staff hands and clothing. EBP are indicated for residents with any of the following .wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Record review of the facility's policy titled Infection Control Plan dated 2019 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. Infection control program - the facility will establish an infection control program under which it - investigates controls and prevents infections in the facility. At least annually and on an as needed basis the facility will conduct a facility wide assessment to determine the resources needed to maintain an efficient and up to date infection control program. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Implement hand hygiene (Hand washing) practices consistent with accepted standards of practice to reduce the spread of infections and prevent cross-contamination. (continued on next page)		

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