

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: 675522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Monahans Managed Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 W 15th St Monahans, TX 79756	
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 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** 26221 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for three of eight residents (Resident #1, #2, and #3) reviewed for infection control. 1. MA A touched Resident #3's pills with her bare hands during medication administration. 2. LVN B failed to prevent cross contamination between Residents #1 and #2 by brining in uncleaned diabetic supplies from one room to another. These failures could place resident's risk for cross contamination and the spread of infection. Finding included: Review of Resident #3's CCD dated 11/01/23, revealed a 90- year- old female admitted to the facility on [DATE] with diagnoses including chronic atrial fibrillation (heart does not beat with a regular beat all the time) and acute respiratory failure (person cannot get enough oxygen). Review of Resident #3's MDS assessment dated [DATE] revealed Resident #3 had a BIMS score of 11 indicating moderately impaired cognition. Review of Resident #3's Care Plan dated 12/10/24 revealed Resident #3 was at risk for frequent infections. Review of Resident #3's Continuity of Care Document, dated 1/24/25 revealed Resident #3 had orders for Aspirin 81 mg dated 11/2/23 for Atrial Fibrillation Carvedilol 12.5 mg dated 4/16/24 for Atrial Fibrillation Digoxin 125 mcg dated 11/1/23 for Atrial Fibrillation Apixaban 2.5 mg dated 11/1/23 fore Atrial Fibrillation (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675522	Facility ID: 675522
		If continuation sheet Page 1 of 5

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Furosemide 20 mg 1/2 tablet for 20 mg dated 1/24/25 stop date 2/6/25 for Heart failure Gabapentin 400 mg dated 11/1/23 for Chronic Pain Guaifenesin 400 mg dated 3/30/24 for Cough Multivitamin dated 11/22/23 Olmesartan 40 mg 1/16/25 for Hypertension Spironolactone 50 mg to five with Furosemide 40mg dated 11/1/23 for Congestive Heart Failure Observation of medication administration for Resident #3 on 01/24/25 at 11:25 a.m. revealed MA A did not wash her hands or use hand sanitizer after administering the previous resident's medication or before preparing Resident #3's medications. MA A added all of Resident #3's currently due medications to a medication cup: Aspirin 81 mg, Carvedilol 12.5 mg, Digoxin 125 mcg, Apixaban 2.5 mg, gabapentin 400 mg, guaifenesin 400 mg, multivitamin, Olmesartan 40mg and spironolactone 50mg. Before entering Resident #3's room, MA A verified medication orders on the electronic medical record (EMR). MA A said the spironolactone had instructions to be given with furosemide, which was being held. MA A stated she would hold the spironolactone and ask the ADON for verification. Using her bare (not gloved, not cleaned) index finger, MA A placed the spironolactone into another medication cup. MA A proceeded to give the remaining medications to Resident #3. In an interview on 1/24/25 at 1:44 p.m., the DON stated she monitored medication administration by watching the staff because she did not have a lot of staff who had been at the facility a long time. The DON said she did annual competencies with the staff at the first part of February and any new hires had an initial check off. In an interview at 1/25/25 at 2:55 a.m., the DON stated the facility's policy about handling medications in general was medications should be popped into cup and skin should not touch a pill at all because then there was a contamination factor. The DON said her expectation with over-the-counter medications were to be tapped into lids and the lid used to dump the pill into the medication cup. Review of Resident #1's Continuity of Care Document, dated 1/24/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Diabetes Mellitus (body does not produce enough insulin causing the body to have abnormally high blood sugar levels). Resident #1 had orders for have blood glucose checks three times a day and insulin administer by a sliding scale beginning 5/26/23. Review of Resident #1's Quarterly MDS Assessment, dated 1/4/25, revealed: She had a BIMS score of 4 of 15 (indicating she was severely cognitively impaired). She had a diagnosis of diabetes. She received injections 6 of 7 days prior to the assessment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Care Plan, beginning 3/15/25, revealed the goal was her Diabetic status would remain stable as evidenced by resident blood sugar staying within the resident's normal limits through the next quarter. Resident #1's Care Plan, beginning 3/15/25, revealed: Enhanced Barrier Precautions will reduce risk of the spread of organisms. Observation on 1/24/24 at 10:15 a.m. during initial rounds revealed Resident #1 was in her room lying in bed. She had a catheter. Review of Resident #2's Quarterly MDS Assessment, dated 11/18/24 revealed: He had a 13 of 15 on his BIMS score (indicating he was cognitively intact) He had a diagnosis of diabetes. He had injections for 7 of 7 days prior to the assessment. His care plan, start date 2/22/24 read he was at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/ physical impairment, slow healing process skin desensitized to pain or pressure related to diabetes mellitus. Identified interventions were to Administer medications as ordered and monitor for side effects and effectiveness. Observation on 1/24/25 at 11:17 a.m. revealed LVN B put on gloves and set up the glucometer (machine for measuring blood sugar levels) and went into Resident #1's room. LVN B was not wearing a gown even though Resident #1 was identified as an EBP resident. LVN B took the blood level reading of Resident #1. LVN B came out with gloves on, looked at surveyor and said, she should probably not be in the hall with gloves on. LVN B kept the gloves on. LVN B put the lancet she used to poke Resident #1's finger into the sharps container. With the same gloved hands, LVN B grabbed the top drawer of the medication cart, realized it was locked, put her hands in her pocket pulled out the keys, unlocked the cart, put the keys back into her pocket. LVN B kept the same dirty gloves on, found a container of strips for the glucometer and another lancet, shut the medication cart drawer, and locked it. LVN B, with the same contaminated gloves, returned to Resident #1's room. LVN B with the same dirty gloves opened the container of glucometer strips, stuck her finger into the container and pulled out a glucometer strip, then laid the container of glucometer strips on Resident #1's bed. With the same gloves, LVN B used a new lancet and stuck Resident #1's finger and took the glucometer reading. With the same gloves, LVN B took all the supplies to the medication cart, placed the container of glucometer strips onto the top of the medication cart, disposed of the used lancet, then disposed of the gloves. LVN B cleaned her hands with ABHG and cleaned the glucometer. LVN B did not clean the bottle of glucometer strips. LVN B put on new gloves, took the glucometer, and the (uncleaned) bottle of glucometer strips. LVN B went into Resident #2's room which also had an EBP posting on the door frame, placed everything on the dresser. LVN B put her finger down the container of glucometer strips, and performed the blood glucose reading. LVN B took her supplies, left the room, took off her gloves, cleaned her hands with ABHG and cleaned the glucometer. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 1/24/25 at 11:36 a.m., LVN B stated she was an agency nurse, but had worked at the facility before. LVN B said if she could do anything different, she would have changed gloves more often and used disinfecting wipes on the glucometer instead of alcohol wipes, but she used what she had. LVN B said she would have changed gloves more often to prevent cross contamination, and she was not aware of everything she touched with the one pair of gloves. State surveyor reviewed the list with her, and her response was wow. LVN B said EBP meant she was supposed to wear a gown and gloves. LVN B said this applied to anyone who had a catheter, indwelling device or wound. LVN B stated most facilities had it posted on the door and most facilities had supplies outside the door. LVN B said she did not notice supplies outside the door. LVN B and state surveyor went to Resident #1's room. There was a sign posted but no PPE outside of the room in any fashion or visually available in the room. LVN B said there was a sign, and she was aware Resident #1 had a catheter, and could see the catheter. LVN B admitted she was aware she needed to wear a gown and did not wear one because there were none outside of the room. LVN B said the point of EBP was to protect the resident from other infections. Interview on 1/24/25 at 11:58 a.m., the DON stated she had a container of gowns behind the nurse's station because the other containers the facility had went missing. The DON said there were a couple on order. The DON said the facility did have the type of gown container that could be hung over the door. The DON said having the gowns at the nurse's station was not an effective process because the staff had to go all over the building. The DON stated she had four residents on EBP. Interview on 1/24/25 at 2:55 p.m., the DON explained the mechanics of cross contamination. She stated cross contamination happened when anyone did not use gloves or held linens too close to the body and the contaminate goop gets on you and you go into the next room. She said the same thing would happen when a person had gloves on. The DON stated gloves would cause cross contamination if it had germs on the surface and the staff go across hall with gloves on the staff had the risk of bringing contamination across the hall. The DON stated the Medication Cart could be contaminated because if the gloves touched the resident, they were dirty, and the gloves should have been removed and the nurse's hands should have been sanitized. The DON stated the keys to the medication cart were contaminated. The DON said the glucometer strips were now contaminated all the others and the nurse impaired the integrity. The DON said she trained nurses to tap the bottle like you would a pill until a strip comes out. The DON stated the outside of tube was contaminated when it touched the resident's bed. The DON said Resident #2 currently did not qualify for EBP, She stated he had pseudomonas UTI but it had resolved. Review of in-services reveal the facility trained staff on EBP policy on 1/17/25: The facility's policy and procedure on Enhanced Barrier Precautions, undated, revealed: Enhanced barrier precautions are utilized to reduce transmission of multi-drug resistant organisms to residents. Policy Interpretation: Enhanced barrier precautions are used as an infection prevention and control intervention to reduce to transmission of multi-drug resistant organisms to residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced barrier precautions employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Enhanced barrier precautions are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. B indwelling devices include urinary catheters. Review of in-services revealed the facility in-served staff on the 6/21/24 on Glove use: Review of the facility's policy and procedure on Personal Protective Equipment - Using Gloves, revised October 2010, revealed: Purpose: To guide the use of Gloves Objective: To prevent the spread of infection. Review of the facility's policy and procedure on Handwashing/Hand Hygiene, revised April 2012, revealed: The facility considered hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, used an alcohol-based hand rub containing 60 - 90% ethanol or isopropanol for all the following situations: before preparing or handling medications. Review of the facility's policy and procedure on Administering Medications, revised December 2012, revealed: Medications shall be administered in a safe and timely manner. Staff shall follow established infection control practices (e.g. handwashing, antiseptic technique, gloves, isolation precautions etc.) for the administration of medications, as applicable.		