

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 02/27/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46998 Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible and includes ensuring that the resident could receive care and services safely and that the physical layout of the facility maximized resident independence and did not pose a safety risk for 1 of 4 hallways (hall 100) and 1(Resident #2) of 3 residents reviewed for clean homelike environment. 1. The facility failed to ensure Hallway 1 did not smell of urine. 2. The facility failed to ensure Resident #2 did not have a dirty bed linens. These failures could place residents at risk of residing in an unsafe, unsanitary, and uncomfortable environment. Findings include: 1. Observation on 02/24/25 at 8:14 AM, with the Administrator, revealed her coming down hallway 1 to get state agency. Walking down the hallway smelled of urine. During an interview on 02/25/25 at 4:50 PM, with the Administrator, she stated the day the state survey agency was in hallway 1 and went to get him she could smell the odor of urine in the hallway. The Administrator stated the urine smell was strong and was inappropriate and she would not like being in a place where it smelled like urine. The Administrator stated that housekeeping was responsible for cleaning and should have cleaned the urine smell. 2. Observation on 02/24/25 at 8:21 AM, revealed, Resident #2's white bed sheets had a large brown unknown substance on it. During an interview on 02/24/25 at 2:09 PM with Resident #2, she stated the facility staff went to change out her bed sheets. Resident #2 did not respond and turned her head away, when asked about the brown unknown substance on the bed sheets. The interview was terminated. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 10:24 AM with the DON, she stated the CNAs were to be checking the resident beds to ensure they were clean and made. The DON stated it was not okay to have dirty or stained sheets. The DON stated it was a dignity issue. During an interview on 02/25/25 at 10:44 AM with CNA C, she stated when residents got up for the day the bed sheets, if they were dirty were picked up and changed for new ones. CNA C stated the residents deserved clean sheets and it was unsanitary to leave them on the bed. CNA C stated it was everyone's responsibility for ensuring the bed sheets were clean and changed. During an interview on 02/25/25 at 4:50 PM with the Administrator, she stated it was the responsibility of the CNAs to change the bed sheets for the residents. The Administrator stated it was inappropriate for the resident to have dirty and or stained sheets. The Administrator stated it was a dignity issues for the residents. During an interview on 02/27/25 at 8:27 AM with CNA A, she stated staff were expected to change the bed sheets of the residents. CNA A stated this was to keep it clean and sanitized which was the responsibility of the CNAs. CNA A stated any dirty or stained sheets would not be appropriate and she would not like it if she had dirty or stained sheets. Record review of the facility's Homelike Environment Policy, dated 02/2021, revealed Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Clean, sanitary, and orderly environment, inviting colors and decor, clean bed and bath linens that are in good condition.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 4 residents (Resident #3) reviewed for accuracy of MDS assessment. The facility failed to ensure Resident #3's quarterly MDS, dated ,d+[DATE], accurately reflected the residents' behaviors. This deficient practice could place residents at risk of not receiving adequate care. Findings include: Record review of Resident #3's face sheet, dated 02/25/25, revealed an admission to the facility on [DATE] and re-admission on 07/19/24 to the facility. Record review of Resident #3's hospital history and physical, dated 07/05/24, revealed a [AGE] year-old male with diagnoses which included [NAME]-Korsakoff disorder (a life-threatening brain disorder caused by a severe deficiency of thiamine, or vitamin B1), Dementia, and anxiety disorder. Record review of Resident #3's MDS, dated ,d+[DATE], revealed a moderate cognitive impairment BIMS score of 12 to recall and or make daily decisions. Behaviors were not coded for any behaviors. Record review of Resident #3's Care Plan, dated 03/30/23, revealed Problem: Resident has verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others). Resident will verbalize understanding of need to control verbal abusive behaviors. Maintain a calm, slow, understandable approach. Remove resident from group activities when behavior was unacceptable. During an interview on 02/26/25 at 10:54 AM with the MDS Coordinator, she stated Resident #3 had behaviors in 01/25 and the MDS did not reflect this in the Behavioral Section (E) of the MDS. The MDS Coordinator stated the MDS was incorrect for Resident #3's 01/2025 MDS assessment. The MDS Coordinator stated the negative outcome could be the inaccurate MDS would create an inaccurate care plan and billing would not be accurate. The MDS Coordinator stated it was her responsibility for ensuring the MDS assessment was accurate and correct.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review the facility failed to develop a comprehensive person-centered care plan for each resident , consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment which were to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 4 of 4 residents (Resident #3, Resident #4, Resident #5, Resident #6) reviewed for care plans. 1. The facility failed to implement a comprehensive person-centered care plan for Resident #3's physical altercation with Resident #4 on 07/10/24. 2. The facility failed to implement a comprehensive person-centered care plan for Resident #4's incident on 07/10/24 with Resident #3 in which Resident #3 physical hit Resident #4. 3. The facility failed to implement a comprehensive person-centered care plan for Resident #5's physical altercation with Resident #6 on 07/21/24. 4. The facility failed to implement a comprehensive person-centered care plan for Resident #6's incident on 07/21/24 with Resident #5 in which Resident #5 physical hit Resident #6. These deficient practices could place residents at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings include: 1. Record review of Resident #3's face sheet, dated 02/25/25, revealed an admission to the facility on [DATE] and re-admission on 07/19/24. Record review of Resident #3's hospital history and physical, dated 07/05/24, revealed a [AGE] year-old male with diagnoses which included [NAME]-Korsakoff disorder (a life-threatening brain disorder caused by a severe deficiency of thiamine, or vitamin B1), Dementia, and anxiety disorder. Record review of Resident #3's MDS dated ,d+[DATE], revealed a moderate cognitive impairment BIMS score of 12 to recall and or make daily decisions. Record review of Resident #3's Care Plan, dated 03/30/23, revealed Problem: Resident has verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others). Resident will verbalize understanding of need to control verbal abusive behaviors. Maintain a calm, slow, understandable approach. Remove resident from group activities when behavior was unacceptable. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/25 at 9:46 AM with the DON, she stated Resident #3 had an incident on 07/10/24 in which he hit another resident. The DON stated she did not see Resident #3 had a focus area care planned for the incident in which he had a physical behavior. The DON stated the purpose of the care plan was to direct staff as far as the resident had a problem or condition and to provide to care. The DON stated the negative outcome of not having it care planned would be staff not monitoring for and where and how to intervene. The DON stated for Resident #3 the staff would not know to intervene if he had a physical behavior placing the other residents at risk. The DON stated the MDS department, and the nurses were responsible ensuring the comprehensive care plans were accurate. During an interview on 02/25/25 at 3:00 PM with the Administrator, she stated Resident #3 had an incident on 07/10/24, were he hit another resident. The Administrator stated she would have to check to see if it was care planned and should have been care planned. The Administrator stated if it was not documented in the care plan it did not happen. The Administrator stated the purpose of the care plan was to inform the resident or representative party of a complete picture of the care the resident was being provided. The Administrator stated the negative outcome would be the resident or the representative party would be they would not make informed decisions that were mindful. The Administrator stated the DON, and the Social Worker were responsible for ensuring the care plans were accurate. 2. Record review of Resident #4's face sheet, dated 02/25/25, revealed admission to the facility on [DATE] and re-admission on 09/15/24. Resident #4 was a [AGE] year-old male with diagnoses which included Diabetes Mellitus, chronic pain due to trauma, major depressive disorder. Record review of Resident #4's Care Plan, reviewed on 02/25/25, revealed there was no focus area nor interventions in place for the resident-to-resident altercation on 07/10/24. During an interview on 02/25/25 at 9:46 AM with the DON, she stated she did not see the interventions care planned for Resident #4 any focus area or interventions for the incident he had with Resident #3 on 07/10/24 in which they got into a physical altercation. 3. Record review of Resident #5's face sheet, dated 02/25/25, revealed admission to the facility on [DATE] and re-admission on 01/29/25. Resident #5 was a [AGE] year-old female which diagnoses which included Cerebral Palsy and intellectual disabilities. Record review of Resident #5's annual MDS, dated [DATE], revealed there was no BIMS score taken to measure the cognition of impairment of the resident. Record review of Resident #5's care plan, reviewed on 02/25/25, revealed there was not a focus area or interventions documented for the altercation on 07/21/24 with Resident #6. Record review of Resident #5's progress notes, dated 07/21/24, revealed Another resident in wheelchair refuse to give a different resident the cordless phone state, 'This was her phone. She was not giving it up.' This resident struck another resident in the face with a closed fist and began crying, both residents were separated and taken to their rooms. During an interview on 02/26/25 at 10:54 AM with MDS Coordinator, she stated there were not interventions or focus areas in the care plan for Resident #5's altercation with Resident #6 on 07/21/24. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/25 at 10:28 AM with the DON, she stated Resident #5 had a physical altercation with Resident #6 in which she hit her while trying to get the phone. The DON stated it was not care planned for both Resident #5 and Resident #6. 4. Record review of Resident #6's face sheet, dated 02/25/25, revealed admission to the facility on [DATE] and re-admission on 09/30/24. Resident #6 was an [AGE] year-old female with a diagnosis which included anxiety disorder. Record review of Resident #6's quarterly MDS, dated [DATE], revealed a severely impaired cognition BIMS score of 7. Resident #6 was able to recall or make daily decisions. Resident #6 had diagnoses which included dementia, anxiety and depression. Record review of Resident #6's care plan, reviewed on 02/25/25, revealed there was no focus area or interventions documented for the incident with the physical altercation incident on 07/21/24. During an interview on 02/26/25 at 10:54 AM, with the MDS Coordinator, revealed the MDS department and the DON were responsible for the care plans and ensuring they were accurate. The MDS Coordinator stated the purpose of a care plan was to provide the best service for the resident and if the resident had a problem, then the care plan would address the steps to help provide the best care for the resident. The MDS Coordinator stated Resident #3 and Resident #4 did not have focus areas with interventions addressed to each resident with their specific incident. The MDS Coordinator stated the risk would be the facility staff not knowing how to care for the resident(s). Record review of the facility's Comprehensive Assessments Policy, dated 10/2023, revealed Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by CMS.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 (Resident #3) reviewed for pharmacy services. The facility failed to record Tramadol-50 mg Schedule IV tablet was given to Resident #3 at 7:30 AM per physician orders in the narcotic logbook. This failure could place residents at risk for being over mediated which could result in medical complications and drug diversion. Findings include: Record review of Resident #3's face sheet, dated 02/25/25, revealed admission to the facility on [DATE] and re-admission on 07/19/24. Record review of Resident #3's hospital history and physical, dated 07/05/24, revealed a [AGE] year-old male with diagnoses which included [NAME]-Korsakoff disorder (a life-threatening brain disorder caused by a severe deficiency of thiamine, or vitamin B1), Dementia and anxiety disorder. Record review of Resident #3's MDS, dated ,d+[DATE] revealed, a moderate cognitive impairment BIMS score of 12. Resident #12 was able to recall and or make daily decisions. Record review of Resident #3's Orders, dated 09/18/23, revealed Tramadol - Schedule IV tablet- 50 mg oral four times a day. at 7:30AM, 1:00PM, 7:30PM, 1:00AM. Observation and interview on 02/26/25 at 12:49 PM with the MA, she stated observed logging on the bingo card (medication card) and then looked at the narcotic logbook. The MA was seen writing down that tramadol was given in the morning and then writing med error next to it. The MA stated she forgot to log down the tramadol -50 mg which was given in the morning to Resident #3 at 7:30 AM. MA stated it was expected to log it in the narcotic logbook and not doing it would be considered a medication error. During an interview on 02/26/25 at 1:19 PM with the Physician, he stated narcotic medications were given had to be documented on the narcotic logbook as it was being taken out to be given. The Physician stated logging the narcotic that was taken out was for counting purposes and had to be documented in the narcotic logbook. The Physician stated a negative outcome would be the count would be wrong and would not know if the resident received the medication. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 4:37 PM with the RN , she stated the medication aides gave the narcotics to the residents. The RN stated they were to fill out the narcotic logbook as it was given. The RN stated this was to prevent another nursing staff member from coming by and giving the resident more medication causing the resident to be overly medicated. The RN stated it would also be a med error . During an interview on 02/27/25 at 11:40 AM, with the DON, he stated Resident #3 had an order for Tramadol-50 mg. The DON stated when giving the medication since it was a narcotic, it had to be logged in the narcotic logbook at the same time it was going to be given. The DON stated not logging it in the narcotic logbook would throw off the bingo card (the medication card) and show that it was off by one medication pill. The DON stated the risk would be the resident could be over mediated or the medication could be stolen by facility staff. Record review of the facility's Administering Medications Policy, dated 04/2019, revealed Medications are administer in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training .		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 46998 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 washing machine and 1 of 4 resident wheelchair brakes reviewed for essential equipment. 1. The facility did not provide necessary repairs for 1 industrial washing machines. 2. The facility failed to ensure Resident #1's wheelchair brakes were not broken These failures could place residents at risk of not having clean clothes to wear and place residents at risk of function mobility and injuries. Findings include: Observation and interview on 02/24/25 at 8:40 AM with Resident #1 revealed the right wheelchair brake would not disengage, and the handle was observed loose. Resident #1 was observed trying to move his wheelchair with his right arm/hand and moving slowly and veins in his arm could be seen popping out of his right arm/hand. Resident #1 did not have any legs as they were amputated. During an interview on 02/24/25 at 2:31 PM Resident #1 stated he told RN on 02/23/25 in the evening that his wheelchair brake was broken. Resident #1 stated she told him okay and walked away. During an interview on 02/25/25 at 10:44 AM with CNA C, she stated the maintenance department had a maintenance logbook by their office to put in work orders for broken items. CNA C stated it was expected for everyone to put work orders in the maintenance logbook for broken items. CNA C stated not doing so could be a hazard to the residents. Observation and interview on 02/25/25 at 2:41 PM with the DON revealed, the DON looked at Resident #1's wheelchair brake. Resident #1 was observed giving the DON the screw and another metal piece in the DON's hand. The DON stated she was not notified of the broken wheelchair brake and was generally notified of issues. The DON stated it was expected of the nursing staff to report any broken equipment to the charge nurse, physician and the DON. The DON stated the equipment should be pulled and not used and looked at. The DON stated by looking at Resident #1's broken right wheelchair brake, it was not reported as it should have been done. The DON stated the risk was mobility and injury. Observation and interview on 02/25/25 at 2:49 PM with the Maintenance Director revealed the Maintenance Director observed Resident #1's right wheelchair brake. The Maintenance Director stated he verbally gave an in-service to the facility on how to report broken items. The Maintenance Director stated there was a maintenance logbook in which they were to write down the name, date, time of the broken item (work orders). The Maintenance Director stated sometimes the staff told him of the broken items (work orders), but it was expected for the facility staff to document it in the maintenance logbook because he did have a lot of work and might forget to fix it. The Maintenance Director stated the risk for Resident #1 would be him rolling off the wheelchair and affect his mobility. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 2 of 2 (Broken blinds), 2 warped tiles, 3 holes in the walls, 1 exit door missing sweep of 4 exit doors, and 1 of 1 maintenance log reviewed for environment. 1. The facility failed to ensure the blinds were not broken. 2. The facility failed to ensure floor tiles were not warped. 3. The facility failed to ensure there were not holes in hallway 3 and a hole in the hall leading to the back smoking patio/laundry room. 4. The facility failed to ensure the hallway 1 Exit door was not missing a sweep and created a seal on the mid-top side of the door to not expose the outside elements. 5. The facility staff failed to input broken items into the maintenance work order log. These failures could residents at risk of living, working and visiting in an unsafe, unsanitary, and uncomfortable environment. Findings include: Observation on 02/24/25 at 8:04 AM revealed in hallway 1 in room [ROOM NUMBER] the blinds were broken. Observation on 02/24/25 at 8:21 AM revealed in room [ROOM NUMBER] had broken blinds. Observation on 02/24/25 at 8:37 AM revealed in hallway 3 there was a large scrap hole on the bottom wall just above the border near room [ROOM NUMBER] around a foot or more in length. On the opposite side of the wall towards the back smoking/patio hall was another hole just above the border around 4-5 inches in lengths and around 2-3 inches wide. On the floor was two long warped floorboards with 2 wheelchairs next to them. During an interview on 02/25/25 at 4:30 PM with the Administrator, she stated the washer and drier had broken down. The Administrator stated the facility fixed the drier and was sending resident clothes to the laundry mat until the washer got fixed. The Administrator stated the residents had their clothes washed and cleaned. During an interview on 02/25/25 at 4:50 PM with the Administrator, she stated if something was broken then it needed to be removed until it was fixed. The Administrator stated the staff were to report it and the department heads would remove the broken item. The Administrator stated it was expected and the responsibility of the staff and everyone was to report broken items. The Administrator stated not reporting broken items could be a risk of residents hurting themselves. (continued on next page)		

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 02/27/2025
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 9:12 AM with the Maintenance Director, he stated the residents were always breaking the blinds and the facility staff placed work orders in the maintenance logbook. The Maintenance Director stated the exit door in hallway 1 was not reported and was missing the seep on the bottom of the door as there was a black blanket placed. The Maintenance Director stated the risk of having the blanket on the floor could be impeding the resident's movement to go outside. The Maintenance Director stated he could see the light coming from outside on the side of the exit door as it was not creating a seal preventing the outside weather and pest from coming into the facility. The Maintenance Director stated the broken walls in hallway 3 were not reported to him and it was not in the maintenance logbook. The Maintenance Director stated the floorboards in hallways 3 had been reported to him a couple of weeks ago but was waiting on corporate to see how they were going to fix it. The Maintenance Director stated it was a fall hazard. The Maintenance Director stated the washer had been broken for about 2-3 weeks and was fixed but the water came out to fast that it overflowed and leaked back onto the laundry room. The Maintenance Director stated the risk would be structural damage and could be creating an environment suitable for mold and pests. Observation and interview on 02/26/25 at 2:54 PM with the DON, revealed she observed the hallway 1 exit door with the black blanket on the floor. The DON was observed looking through the opening of the exit door that was not creating a seal. The DON was observed going to hallway 3 and looking at the holes in the wall and the hole near the smoking back patio area. The DON was observed looking at the floorboards in hallway 3 that were warped. The DON was observed looking at the towel on the floor in the laundry room placed around the washers. The DON stated the blanket on the floor of the exit door in hallway 1 created a trip hazard. The DON stated the holes on the wall were reported two weeks ago and should have been fixed. The DON stated the floorboards were a trip and fall risk. The DON stated the water leaking over into the laundry room could be a trip hazard. During an interview on 02/26/25 at 4:37 PM with RN, she stated the washer was broken for about two weeks and the facility was washing the residents' clothes at the laundry mat. The RN stated she noticed there were towels on the floor around the washers in the laundry room to prevent the water from overflowing into the laundry room. The RN stated the risk would be slippery of the ground for someone walking by creating a hazard for the residents. The RN stated it could also create mold due to the humidity in the laundry room with the drier and water and possibly invite pests. During an interview on 02/27/25 at 9:05 AM with LVN B, she stated the facility had a binder in which facility staff could place the work orders. LVN B stated it was expected to put the room number, date, and time it was reported to maintenance. LVN B stated an in-service was provided about placing work orders. LVN B stated it was expected for the facility staff to be placing work orders for broken items in the facility. LVN B stated the negative outcome would be for safety. During an interview on 02/27/25 at 12:03 PM with the DON, she stated the facility staff were trained and in-serviced on placing work orders. The DON stated it was expected for staff to be placing it in the work order logbook. The DON stated she saw the broken blinds and reported it in the morning meeting and during stand down meeting but failed to place it in the work order logbook. Record review of the facility's maintenance work order log, dated 02/26/25, revealed there was no documentation of work orders for walls being broken, broken blinds, washer/dryer break downs, hallway 1 exit door sweep missing and a gap with the exit door and building mid door. (continued on next page)		

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 02/27/2025
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Maintenance Service Policy, dated 12/2009, revealed Maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations and guidelines. Maintain the building in good repair and free from hazards. Maintain the heat/cooling system, plumbing fixtures, wiring etc., in good working order. The Maintenance Director was responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Records shall be maintained in the maintenance director's office. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Record review of the facility's Work orders, Maintenance Policy dated 04/2010, revealed Maintenance work orders shall be completed in order to establish a priority of maintenance service. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the maintenance director.		