STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676015	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabee Health Care Center	2208 N Loop 250 W Midland, TX 79707

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included locked secured medications, the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 3 medication carts (Rehab hall and secured unit medication carts), 1 of 2 medication rooms (Secured unit medication room) and to maintain locked medication cabinets for 4 of 60 rooms (Residents #9, #10, #28, #94) reviewed for medication storage. The medication cart used for the secured unit had an insulin pen that had been opened and placed into use but had no open date on it. The medication cart used for the rehab hall had 2 insulin vials that had been opened and placed into use but had no open dates on them. The secured unit medication room had opened Tuberculin (TB) vial that had expired. (Tuberculin is used to test for Tuberculosis in the body, Tuberculosis is a contagious infection caused by bacteria that mainly affects the lungs). The medication cabinets for 4 of 60 rooms (Residents #9, #10, #28, #94) were unlocked and unsupervised. The failures could place residents at risk of not receiving the therapeutic benefit of medications or adverse reactions to medications and could place residents at risk for drug diversion or accidental ingestion. Findings include: INSULIN AND EXPIRED TB (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Mabee Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2208 N Loop 250 W Midland, TX 79707	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/04/24 at 02:38 PM revealed the medication room in the secure unit was inspected with LVN A present. There was a small refrigerator that contained a vial of Tuberculin that had an open date of 10/30/24 and the box indicated to discard 30 days after opening. LVN A said she was not aware the TB solution had already expired. LVN A said as far as she knew it was each nurse's responsibility to remove any expired medications from the refrigerator. LVN A said if someone received a test with that expired TB solution it could lead to false readings. During an observation and interview on 12/04/24 at 05:39 PM revealed the medication cart in the rehab hall was inspected with LVN B present. Inside the cart were 2 insulin vials that had been opened and placed into use and had no open date written on them. The insulin boxes and vials indicated Discard unused portion 28 days after first opening, Use within 28 days after initial use. LVN B said she had not opened the insulin vials and had no idea who had done that. LVN B said whenever she opened an insulin vial she dated them and as far as she knew every nurse was responsible for dating the insulin when they opened it. LVN B said if an expired insulin was administered to a resident it might not be as effective and lower the resident's blood sugar. During an observation and interview on 12/05/24 at 11:04 AM revealed the medication cart in the secure unit was inspected with LVN A present. Inside the cart was an insulin pen that had been opened and placed into use but had no open date written on it. The insulin pen indicated that it was good for 28 days after being opened. LVN A said she was not aware of the insulin pen not being dated. LVN A said she would always date the insulin pens when she opened them so that they would know when to dispose of them. LVN A said if the insulin pens were not dated and if used after 28 days it could lead to resident's sugar not being lowered and the insulin could have lost its potency. During an interview on 12/05/24 at 05:32 PM the DON was made aware of the opened and undated insulin medications and also the expired TB vial in the medication room. The DON said it was expected for the nursing staff to date the insulin and TB medications when they were opened. The DON said the nursing staff was supposed to date it because those medications were usually good for only 30 days. The DON said they did random audits of the medication rooms and medications carts but not at all times. The DON said if staff administered expired insulin or TB test that could lead to not being as effective. The DON said the failure occurred because the nursing staff did not date the insulins or removed the expired TB from the medication room. During an interview on 12/05/24 at 05:48 PM the Administrator was made aware of the opened and undated insulin medications and also the expired TB vial in the medication room. The Administrator said she expected for the nursing staff to have applied standard nursing practices such as following nursing guidelines they were taught in nursing school. The Administrator said if the staff administered an expired medication it may or may have a negative outcome. The Administrator said the failure because the nurses that open the insulins failed to date the vials and pen and they also failed to remove the expired TB vial from the medication room. During an interview on 12/05/24 at 06:02 PM the DON said they did not have a specific policy or any current training in regard to dating medication when opened. UNLOCKED MEDICATION CABINETS (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's Resident Face Sheet, dated 12/5/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, hypertension (high blood pressure), hypothyroidism (low thyroid levels), Arthritis, Anxiety, Allergies, incontinence, constipation, and dermatitis. Review of Resident #9's Quarterly MDS Assessment, dated 10/11/24, revealed: She had long and short-term memory impairment with moderately impaired decision-making skills. She showed signs of delirium that included disorganized thinking that fluctuated. Triggered medications included an anti-anxiety and a diuretic. Review of Resident #9's Care Plan, last revised 9/25/24, revealed: Problem: History of elevated Blood pressure and needs medication to keep it controlled. Goal: Blood pressures within normal range for resident Approaches included: Administer antihypertensive medication as ordered. Problem: Pain. Will not show decline in mobility due to pain not controlled. Goal: Remain comfortable as disease progresses. Approaches included: Administer pain medications as ordered. Takes acetaminophen twice a day routinely. Problem: Psychosocial Wellbeing, Depression: Chronic. Goal: Depression will not increase as evidenced by participation in activities, leaving room, and absence of crying and making statements that she is depressed. Approaches included: Assess effectiveness of anti-depressant medication therapy. Review of Resident #9's Continuity of Care Document, dated 12/5/24, revealed ordered medications: Benazepril 40 mg tablet, once a day for Hypertension. Citalopram 10 mg, once a day for anxiety Donepezil 10mg , once a day for dementia Hydrochlorothiazide 12.5mg capsule once a day for hypertension. Observation on 12/3/24 at 3:51 p.m. revealed Resident #9's resident room open, the medication cabinet in her room was closed but did not lock. Resident #9 was out of her room. Inside the cabinet were cards of: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Memantine 28 mg Benazepril 40 mg Hydrochlorothiazide 12.5mg capsules Citalopram 10mg Donepezil 10mg tablets And a box of Albuterol Sulfate. Interview on 12/4/24 at 12:50 p.m. LVN A stated she never checked the door to the medication cabinets, she put the key in, and the doors unlocked. LVN A was shown Resident #9's cabinet and stated Oh goodness. LVN A said she switched to the cabinet the medications were currently in because the other cabinet in the room required to be slammed and she (LVN A) did not want to scare Resident #9 like that. LVN A stated she guessed as the charge nurse she was responsible for monitoring the doors. LVN A said there were 4 nurses who passed medications: herself, another day shift nurse, and two night shift nurses. LVN A stated she never checked the cabinets to see if they locked before now; she just assumed they would lock. LVN A stated, It's like the gun cabinet; you can bet I will be double checking now. LVN A stated she never received an in-service about checking to make sure the cabinets were [NAME]. LVN A added Why would we? It's a lock; it's supposed to lock. Review of Resident #10's Face Sheet revealed she was an [AGE] year-old female admitted to the facility 6/18/20 with diagnoses including Alzheimer's disease, generalized anxiety disorder, protein-calorie malnutrition, constipation, pain, nausea, and diarrhea. Review of Resident #10's Annual MDS assessment dated [DATE] revealed: She had long and short-term memory impairment with severely impaired decision-making skills. She showed signs of delirium that included continuous inattention. Review of Resident #10's Continuity of Care Document, dated 12/5/24, revealed the following orders: Lactulose 10grams/15ml give 30ml by mouth three times a day as needed for constipation (Order Date 10/26/23) Lactulose 10grams/15ml give 30ml three times a day for constipation (Order Date 12/5/24) Observation on 12/03/24 at 4:00 pm revealed Resident #10's door open and the built-in medication cabinet in Resident #10's room was unlocked. One 32-ounce bottle of Lactulose (liquid laxative) was observed in the unlocked medication cabinet. Resident #10 was not in the room at the time of the observation. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #28's Resident Face Sheet, dated 12/5/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis including Pseudomonas (having the pneumonia virus), anemia (low iron), pressure ulcer of the left hip (bed sore), tachycardia (unstable heart rhythm), altered mental status, dementia, pain, allergies, arthritis, hypertension (high blood pressure), hyperlipidemia (high cholesterol), Diabetes. Review of Resident #28's 11/17/24 Admission MDS, dated [DATE], revealed: He had long and short-term memory problems with severely impaired cognitive ability. He showed signs of delirium including inattention and disorganized thinking that were continuously present. Triggered medications included anti-anxiety, and opioid medication. Review of Resident #28's Care Plan, initiated 11/26/24, revealed: Category: Pain: Chronic pain due to arthritis and general aches and pains. Goal: Will voice or show relieve or reduction in pain within one hour after receiving intervention for pain. Approaches included: Administer scheduled ibuprofen and monitor effects. Category: Hyper/Hypoglycemia (high and low blood sugar) Goal: Will remain free of complications from hyper or hypoglycemia Approaches included: Administer Metformin as ordered, hold if Capillary Blood Glucose is below 140. Review of Resident #28's Continuity of Care Document, dated 12/5/24, revealed orders for: Diclofenac Sodium 1% gel Four times a day Ibuprofen 600 mg tablets every 6 hours Hyoscyamine sulfate 0.125 mg tablet every 4 hours as needed Metformin 500 mg once a day hold for blood glucose level less than 140. Vitamin B1 100mg tablet once a day Loratadine 10mg once a day Observation of Resident #28's room on 12/4/24 at 11:20 AM revealed Resident #28 in bed asleep. Resident #28's door was open. The medication cabinet in Resident #28's room came open. In Resident #28's medicine cabinet were: 2 boxes of Diclofenac Sodium 1% gel Four times a day (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ibuprofen 600 mg tablets every 6 hours Hyoscyamine sulfate 0.125 mg tablet every 4 hours as needed Metformin 500 mg once a day hold for blood glucose level less than 140. Vitamin B1 100mg tablet once a day Loratadine 10mg once a day Review of Resident #94's Resident Face Sheet, dated 12/5/24, revealed she was an 81-year-femaled admitted to the facility on [DATE] with diagnoses including hypokalemia (low potassium), hypertension (high blood pressure), hyperlipidemia (high cholesterol), hypothyroidism (low thyroid), hypo-somality (sleeps too much), edema (swelling, usually to lower extremities), allergies, and respiratory failure (difficulty breathing). Review of Resident #94's Care plan, updated 10/16/24, revealed: Problem: Nutritional Status: At risk in nutrition/hydration due to needs for assist with meal intake, risk for weight changes due to edema and diuretic use. Goal: Will encourage at least 75% of meal and offer fluids regularly Approaches included: Administer sodium and diuretic medication daily as ordered. Problem: Sleep: Difficulty with insomnia. Goal: Will be able to sleep 6 - 8 hours at night. Approaches included: Assess effectiveness of medication therapy Melatonin. Review of Resident #94's Continuity of Care Document, dated 12/5/24, revealed orders: Fexofenadine 180 mg -pseudoephedrine 240mg once a day Amlodipine 10mg once a day Digoxin 0.125mg once a day. Furosemide 20mg twice a day Gabapentin 100mg 2 capsules three times a day Levothyroxine 100 mcg tablet once daily Melatonin 3 mg tablet at bedtime Montelukast sodium 10mg once day (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Potassium Chloride 20 meq tablet, 5 tablets to equal 100 meq three times a day. Simvastatin 20 mg at bedtime Sodium Chloride 1,000 2 tablets twice a day Rivaroxaban 20mg at bedtime Observation on 12/04/24 on 12:01 PM revealed Resident #94 in the dining room. The door to the room was open the medication cabinet in her room was completely open with the work ledge down. All medications were easily accessible to people passing by. Medications included: Montelukast sodium -10 mg Vitamin D-1 Amlodipine desolate 10mg Levothyroxine 10mg in am Digoxin 0.125 mg Furosemide 20 mg bid Gabapentin 100mg Rivaroxaban 20 mg Simvastatin 20 mg Sodium chloride 1,000 mg Potassium 20 meq Iron tab ferrous sulfate 65 mg Melatonin 3 mg Fexofenadine 180 mg -pseudoephedrine 240mg (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 12/4/24 at 12:35 PM, LVN C said she did not have trouble keeping cabinets locked. She said only the nurses had keys. LVN C was shown Resident #94's cabinet. LVN C said she just did not lock it behind her because she was in a rush. LVN C explained she gave Resident #94 their meds, closed the door and forgot to lock the cabinet because she was busy taking Resident #94 to the dining room. LVN C was shown Resident #28's medicine cabinet that was unlocked. LVN C stated the cabinets were supposed to be locked. LVN C stated they closed and should lock automatically. LVN C said she covered all medications on that cottage (20 rooms) and no one had orders to self-medicate. LVN C attempted to show that the cabinet closed automatically and admitted the cabinet did not lock automatically and she had to push the door closed and lock the door with the key. Interview on 12/4/24 at 1:18 p.m. the DON and Administrator were informed of the cabinets that were unlocked and unattended. The DON stated she had never found a medication cabinet unlocked when she had the occasion to have the medication keys. The DON said she did not know why they would be unlocked, and it was brand new information to her. The Administrator added the Maintenance Department did not check the cabinet doors in the rooms to ensure they locked. The DON said she would rather nursing staff did that because of the medication. The DON said the nurses must not be pushing hard enough on the doors. The DON said there was no in-services on locking the cabinets because there did not need to be one until now. The Administrator and DON both said there was no policy about unlocked medication cabinets when a policy was asked for.