

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 02/26/2026
NAME OF PROVIDER OR SUPPLIER Mabee Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' right to a safe, clean, comfortable, and homelike environment for Resident #20, Resident #31 and Resident #46 in that: The facility failed to ensure that the hot water temperatures in the sinks for 3 resident rooms did not exceed the maximum of 110 degrees Fahrenheit (F). The findings included: Record review of Resident 46's face sheet dated 02/26/2026 indicated she was admitted to facility on 02/10/2026 with diagnoses of muscle weakness and muscle spasms. She was [AGE] years of age. Record review of Resident #31's admission record dated 02/26/2026 indicated he was admitted to facility on 01/05/2023 with diagnoses of Alzheimer's disease and muscle weakness. He was [AGE] years of age. Record review of Resident #31's MDS dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Record review of Resident #20's admission record dated 02/26/2026 indicated he was admitted to facility on 08/12/2021 with diagnoses of heart failure and muscle weakness. He was [AGE] years of age. Record review of Resident #20's MDS dated [DATE] indicated in part: BIMS = 15 indicating resident was cognitively intact. Interview on 02/24/2026 at 4:30pm the Maintenance Assistant Director was made aware of the water temperatures observed in multiple resident rooms in both of the cottages. The Director said he believed the normal hot water temperature was supposed to be about 120 degrees Fahrenheit (F). The Director said the temperature was controlled at the mixing valves and that they did not checked the water temperature in the resident rooms. The Director brought his thermometer and checked the temperature in one of the resident rooms that had been noted to have water temperature if 118.5 degrees F. The Director's thermometer revealed the water temperature was 119 degrees F. The Director said he was still in the process of learning about safe water temperature levels and that he would adjust the temperature. The Director said they would see that the temperature was turned down as soon as possible. (Note: Water temperature was re-checked and noted to be at 105 degrees F). Observation and interview on 02/24/2026 at 11:05 AM the water temperature in the restroom sink was 122 degrees F in Resident #46's room. Resident #46 said she had not noticed if the water was too hot in her restroom. Observation and interview on 02/24/2026 at 11:12 AM the water temperature in the restroom sink was 120 degrees F in Resident #31's room. Resident #31 said he had noted that the hot water at the faucet in his restroom was pretty hot about a week ago. Resident #31 said that he had never burned his hands because he would adjust the temperature at the faucet. Observation and interview on 02/24/2026 at 11:22 AM the water temperature in the restroom sink was 118 degrees F in Resident #20's room. Resident #20 said he had noted that the hot water at the faucet in his restroom was hot couple of weeks ago. Resident #20 said that he had never burned his hands because he would adjust the temperature at the faucet. Interview on 02/26/2026 at 4:00 PM the Administrator said that the expectation was for the maintenance staff to spot check the water temperatures and monitor the temperatures with the mixing valves. The Administrator</p> <p>(continued on next page)</p>		

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>said if the hot water was too hot then it could possibly lead to a resident getting burned. The Administrator said they would be keeping a temperature log from now on. The Administrator said they did not have a policy on monitoring hot water. The Administrator said they went based on the regulations. The Administrator said they had not had any residents burned due to the hot water.</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>Based on observation, interview, and record review the facility failed to ensure each room was designed or equipped to assure full visual privacy for 3 (Rooms C-8, S-8 and S-18) of 4 dual occupancy rooms reviewed for privacy in the facility. The facility failed to ensure that dual occupancy rooms were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: Observation on 02/24/2026 at 2:35 PM of resident rooms C-8, S-8 and S-18 revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately 24 inches from the wall. A beds had a side curtain each but they each had a gap of approximately 30 inches and were unable to allow beds to have total visual privacy. Interview on 02/25/2026 at 4:02 PM the Administrator said if there was no full visual privacy in the resident rooms then there was a possibility of the residents being exposed during resident care. The Administrator said that they did not have a policy on full visual privacy curtains.</p>