| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676015 | A. Building<br>B. Wing | 02/26/2026 |

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

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|---|---|
| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, interview, and record review, the facility failed to post daily information that included the facility name, census, and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 3 days (02/24/2026, 02/25/2026, 02/26/2026) of 3 days observed during survey for staff posting. The facility failed to post the daily staffing information for 02/24/2026, 02/25/2026, and 02/25/2026. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census.During an observation and record review on 02/24/2026, 2/25/2026 and 02/26/2026 revealed the facility's daily nursing posting was located behind closed doors at the nurses' station and failed to indicate the actual hours worked for each direct care staffing, the facility name, the total number and actual hours worked by the staff, and resident census. The posting was just a schedule that staff signed upon arrival to work and was in a binder.During an interview on 02/26/26 at 4:22 PM the DON and Administrator stated they were not aware that total hours and the census needed to be on the posting. The DON and Administrator also stated they were unaware that it had to be posted and visible for residents and the public. The DON stated the names and title by each member of staff were to be signed when they arrived at work, on the floor. The DON stated they were not aware the posting had to indicate the number of hours, the facility name and census.During an interview on 2/26/2026 at 4:30PM the Administrator stated they did not have a policy for daily staffing and just follow the regulations. |

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 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure notices to residents were provided when changes in coverage were made to services covered by Medicare/Medicaid for 3 of 3 residents (Resident #9, Resident #47, and Resident #48) reviewed for resident rights.The facility failed to ensure Resident #9, Resident #47 and Resident #48 was given a Notice of Medicare NON-Coverage CMS form 10123 (NOMNC resident who is not covered on a Medicare Part A skilled nursing stay) and Beneficiary Notice CMS form 10055 (Notice of Medicare Non-Coverage) that inform them how to appeal when residents are discharged from skilled Medicare part A services prior to covered days being exhausted.This failure could place residents, or their representatives, at risk of not being fully informed about services covered by Medicare Part A and not being aware of changes to provided services.Findings include: Resident #9Record review of Resident #9's face sheet dated 02/25/2026, revealed she was admitted to the facility on [DATE] with diagnoses of displaced fracture of right radial styloid process, subsequent encounter for closed fracture with routine healing (fracture in wrist where bone breaks and shifts out of alignment, subsequent encounter refers to the medical and supportive care provided after the surgery to help ensure proper recovery, prevent complications, and restore mobility and function),cardiomyopathy (a group of diseases affecting the heart muscle), muscle weakness (a reduced capacity to generate force), abnormalities of gait and mobility (deviations from a typical efficient walking pattern. Resident #9 remained in the facility as private pay. Discharge from Medicare A date was 12/13/2025 to private pay, length of stay was 62 days.Record review of the CMS form 200052 SNF Beneficiary Protection Notification Review on 2/25/2026 revealed form CMS 10055 and NOMNC was not provided to Resident #9. During an interview on 2/26/2026 at 3:55 pm with the DON, she said Resident #9 was not issued a NOMNC. She said she gave Resident #9 and the Responsible Party a verbal notification. Resident #9 was staying at the facility long term. The DON stated she did not know about the NOMNC form and when she was supposed to give it. She stated they did not have an MDS person in the facility and she completed what was needed at the facility level. The DON stated she was responsible for providing the NOMNC and Beneficiary Notices but did not know she needed to issue the NOMNC. The DON stated the risk of not issuing the forms was residents and the responsible party not being fully informed of their rights. Resident #47Record review of Resident #47's face sheet dated 2/25/26, revealed he was admitted to the facility on [DATE] with diagnoses of fracture of left femur(bone in the thigh), pain, orthopedic aftercare (post discharge phase of recovery following orthopedic surgery). Resident #47 was discharged on 8/28/26. Length of stay was 18 days.Record review of Resident #47's discharge MDS dated [DATE] revealed Resident #47 had a planned discharge to home under care of organized home health service organization. Section C of MDS indicated Resident #47 did not have disorganized thinking. A BIMS was not completed.Record review of the CMS form 200052 SNF Beneficiary Protection Notification Review on 2/25/2026 revealed Resident #47 was not provided with a NOMNC. Resident #48Record review of Resident #48's face sheet dated 02/25/26, revealed she was admitted to the facility on [DATE] with diagnoses of encounter for orthopedic aftercare (post discharge phase of recovery following orthopedic surgery), displaced intertrochanteric fracture or left femur (hip fracture), pain, muscle weakness, unsteadiness on feet. Resident #48 was discharged on 9/18/2025. Length of stay was 19 days.Record review of Resident #48's discharge MDS dated [DATE] revealed Resident #48 had a planned discharge home/community. Resident #48's BIMS score was 15, indicating no cognitive impairment. Record review of the CMS form 200052 SNF Beneficiary Protection Notification Review on 2/25/2026 revealed Resident #48 was not provided with a NOMNC.During an interview on 2/26/2026 at 4:32 pm with the Administrator, she stated the team members responsible for the beneficiary notices was the DON. She said the residents on the Beneficiary Notification Review were not given a NOMNC nor the CMS 10055. She said if the resident<br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | received a NOMNC, then they had a chance to appeal the discharge if they do not agree. The Administrator stated they did not have a policy for this and just followed the regulations. She stated the risk of not completing these forms could result in residents not knowing their rights. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**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 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. |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>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. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents were free from chemical restraints not required to treat the residents' medical symptoms for 2 (Resident #2 and Resident #8) of 10 residents reviewed for unnecessary medications.The facility failed to ensure Resident #2's PRN Lorazepam (medication generally prescribed to treat symptoms of anxiety) was discontinued after 14 days or documented a rationale for the continued provision of the medication.The facility failed to ensure Resident #8's PRN Lorazepam was discontinued after 14 days or documented a rationale for the continued provision of the medication.This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Resident #2Record review of Resident #2's face-sheet dated 02/25/26 revealed [AGE] year-old female with admission date 08/31/2023.Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 7 indicating severe cognitive impairment. Section I-Active Diagnoses noted Resident #2 had Psychiatric/Mood disorder, anxiety disorder. Section N- Medications noted Resident #2 was taking an antianxiety medication.Record review of Resident #2's care plan dated 09/29/23 revealed Resident #2 had anxiety and used antianxiety medications. Interventions included for staff to administer Lorazepam per hospice order, to assess effectiveness of antianxiety medication, and assess mood changes.Record review of Resident #2's Prescription Order of Lorazepam 2mg/mL, amount 0.5 ML (1MG) oral (by mouth) every 1 hour as needed for anxiety and duration of hospice start date, 09/29/25, and Open Ended end date. Resident #8Review of Resident #8's electronic face sheet 2/26/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (term used to describe a group of symptoms that negatively affect memory, thinking, and social abilities), depression unspecified, Parkinsons disease with dyskinesia, with fluctuations (involuntary movements and inconsistent medication effects), pain unspecified.Review of Resident #8's quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 which indicated severe cognitive impairment. Review of Section I:Active Diagnosis noted Resident #8 had a diagnosis of depression. Review of Section N: Medications revealed Resident #8 was receiving anti-anxiety medications.Review of Resident #8's Comprehensive Care Plan last revised 01/22/2026, revealed: Problem: Anxiety, agitation with use of antianxiety. Approach: Administer medication per MD orders, monitor for any side effects.Review of Resident #8's electronic Physician's Orders dated 2/25/2026 revealed: lorazepam 0.5mg tablet; 1 tab; oral; Special Instructions: May administer 1 tab Every 4 Hours, start date 10/16/2025 with no stop date.Review of Resident #8's February 2026 MAR revealed 11 doses of Lorazepam were administered.Review of Resident #8's physician progress note dated 1/15/2026 revealed no evidence of a documented rationale to order PRN Lorazepam for more than 14 days. In an interview on 02/26/2026 at 3:49 PM with the DON, she stated psychotropic medications were to be prescribed for 14 days or have a documented reason on continued use. The DON stated she oversees the antipsychotic medications and the pharmacy recommendations. She stated she had not received a DRR on this medication from the pharmacist. She stated the rationale was that the medications were prescribed by hospice. She stated there was no policy for psychotropic medications, but the facility followed the regulations. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on 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 of 1 (Scharbauer Cottage) of 2 medication cabinets located in the medication room reviewed for controlled substances and for storage of medications.The facility failed to ensure LVN C signed the Controlled Drugs-Audit Record form after counting and verifying that all controlled substances in the medication cabinet had been accounted for with the off- going nurse at the change of shift on 02/25/26.The failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances. The findings include:In a record review and interview on 02/25/26 at 9:40 AM with LVN C, revealed the Controlled Drug-Count Record was not signed on 02/25/26, 6AM-2PM shift for the Nurse On. The Controlled Drug-Count Record for 02/25/26 2PM-10PM shift was signed on Nurse On, and another signature noted for 02/25/26 10PM-6AM shift under Nurse Off. LVN C stated she forgot to sign under 02/25/26 Nurse On for 6AM-2PM shift and signed under 02/25/26 2PM-10PM and 10PM-6AM shifts. She stated it was a mistake and that was not acceptable. She stated nurses were expected to sign under the change of shift time with the 2 nurses coming onto, and leaving, their shift. She stated she worked double shifts, but she was still to sign the Controlled Drug-Count during the shift change. She stated the potential risks of signing ahead of time included inaccurate and possible unavailability of medications for residents. She stated nurses were responsible for Accurate Controlled Drug-Count documentation, and the DON monitored but was not sure how often.In an interview on 02/26/26 at 10:30 AM with LVN A, she stated the Controlled Drug-Count Record form after counting and verifying that all controlled substances in the medication cart had been accounted for only during the change of shift. She stated this was to have both nurses, on-going and off-going nurses, confirm the count of the Controlled medications in the medication cabinet. She stated the nurses doing the count were responsible for signing the Count Record only when doing the count. She stated the ADON monitored the Audit Records daily for accuracy, and the DON was responsible for monitoring the records but was unsure how often. She stated the potential risks of signing ahead of time or not signing could risks residents for inaccurate medication count and availability.In an interview on 02/26/26 at 3:52 PM with the DON, she stated nurses were expected to sign the Controlled Drug-Count Record form during the change of shift and when both on-going and off-going nurse were confirming count. She stated it was only acceptable for nurses to sign the Controlled Drug-Count Record during the change of shift. She stated as the DON, she was responsible for monitoring the Audit Record forms, which was done on a quarterly basis. The DON stated she did not believe there was a risk to residents if nurses sign ahead of time or inaccurately on the Controlled Drug-Count Record. She stated there was no policy regarding Controlled Medications or the Audit forms. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an Infection Control program designed to help prevent the development and transmission of disease and infection to include hand washing and enhanced precautions for 1 resident (Residents #34) of 5 reviewed for infection control in that:The facility failed to place an Enhanced Barrier Precautions sign outside of Resident #34?s door on 02/24/26.This failure could affect the residents who reside at the facility, by placing them at risk for cross-contamination and the spread of infection.The findings were: Record review of Resident #34's face sheet dated 02/25/26 revealed a [AGE] year-old female with admission date 02/02/20 and re-admission date 02/20/26.Record review of Resident #34's Comprehensive MDS dated [DATE] noted there was no BIMS score since Resident #34 was rarely/never understood. Section K-Swallowing/Nutritional status noted Resident #34 had a feeding tube while a resident.In an observation on 02/24/26 at 10:19 AM, Resident #34 was observed in her room, resting in bed with the feeding tube actively infusing 70 ml/hour. There was no EBP sign outside of the room. The enteral feeding was labeled Jevity 1.2 and dated 02/24/26. There were disposable gloves and gowns observed at Resident #34's bedside. Resident #34 was observed waking up but could not answer the surveyor's questions.In an interview on 02/26/26 at 9:25 with LVN A, she stated PPE supplies were located in residents' rooms, in their closets. She stated there were no signs or postings about enhanced barrier precautions (EBP), she stated it was located in the residents' closets. She stated the purpose of staff using PPE was to protect the resident from exposure to bacteria that could potentially cause illness. She stated the potential risks of not having signs outside of resident rooms included staff or visitors to exposing the resident and other residents in the facility since they would not know.In an interview on 02/26/26 at 3:50 PM with the DON, she stated the EBP signs made staff aware of the precautions and PPE was needed to care for the resident. She stated all staff were trained and were aware of which residents required PPE. She stated there was no policy for postings, but the facility followed regulations. She stated there was no potential risk to residents if the EBP postings were not located outside residents' rooms. |