

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #17) reviewed for resident rights, in that:</p> <p>The facility failed to ensure CNA AD and CNA AE completely closed Resident #17's privacy curtain while providing incontinent care.</p> <p>This deficient practice could place residents at-risk of loss of dignity due to lack of privacy.</p> <p>The findings include:</p> <p>Record review of Resident #17's face sheet, dated 09/10/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Dementia (decline in cognitive abilities), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Hypertension (High blood pressure), Chronic kidney disease (gradual loss of kidney function)and, Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood).</p> <p>Record review of Resident #17's Quarterly MDS assessment, dated 08/07/2024, revealed the resident had a BIMS score of 03, indicating she was severely cognitively impaired. Resident #17 was always incontinent of bladder and frequently incontinent of bowel and, required extensive assistance with her ADLs.</p> <p>Record review of Resident #17's care plan, dated 07/22/2022, revealed a problem of has an ADL self-care performance deficit related to Activity Intolerance, Fatigue, with an intervention of TOILET USE: The resident requires extensive assist from (2) staff for toileting.</p> <p>Observation on 09/10/24 at 09:20 a.m. revealed CNA AD and CNA AE did not completely close the privacy curtains while they provided incontinent care for Resident #17, exposing the resident who could be seen from the room's door. Further observation revealed Resident #17's roommate was in the room.</p> <p>During an interview with CNA AD and CNA AE on 09/10/2024 at 9:28 a.m., they confirmed the privacy curtains was not completely closed while they provided care for Resident #17 but it should have been. They confirmed they received resident rights training within the year.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 09/10/2024 at 9:30 a.m., the DON confirmed privacy must be provided during nursing care and Resident #17's privacy curtains should have been closed completely. He confirmed the staff had received training on resident rights within the year and the training was provided by the ADONs and himself. They also check the staff skills annually and as needed. The DON revealed they had no policy regarding the privacy curtain being closed during care.</p> <p>Review of Facility's Resident rights sign posted in the facility revealed You have the right to privacy, including privacy during visits and telephone calls and while attending to personal needs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observations, interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 18 residents (Residents #40 and #9) whose assessments were reviewed, in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #40's quarterly MDS, dated [DATE], correctly documented the resident as receiving an anticoagulant medication.</li> <li>2. The facility failed to ensure Resident #9's, who was a smoker, annual MDS, dated [DATE], did not reflect the resident did not use tobacco.</li> </ol> <p>These failures could place residents at-risk for inadequate care and services.</p> <p>The findings were:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #40's face sheet, dated 09/10/2024, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Heart failure (impairment in the heart's ability to fill with and pump blood), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Hypertension (High blood pressure), Peripheral vascular disease (Blood circulation disorder affecting the vessels outside of the heart and brain) and, Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood).</li> </ol> <p>Record review of Resident #40's Quarterly MDS assessment, dated 06/17/2024, revealed the assessment indicated Resident #40 received an anticoagulant and an antiplatelet.</p> <p>Record review of Resident #40's Physician orders and Medication administration record for June 2024 revealed orders for: Aspirin 81 (antiplatelet) oral tablet chewable. Give 1 tablet by mouth one time a day related to encounter for orthopedic aftercare following surgical amputation and an order for Clopidogrel Bisulfate (antiplatelet) oral tablet 75 mg. Give 1 tablet by mouth one time a day related to peripheral vascular disease.</p> <p>Record review of Resident #40's Medication Administration Record for the month of June 2024 revealed Resident #40 received Clopidogrel Bisulfate Tablet 75 MG and Aspirin 81 mg everyday, as per order, between 06/10/2024 and 06/17/2024.</p> <p>During an interview with MDS Coordinator AF on 09/10/2024 1:05 p.m., MDS Coordinator AF verbally confirmed Resident #40's quarterly MDS was coded as the resident having received an anticoagulant and an antiplatelet when Resident #40 had received Clopidogrel (an antiplatelet) and Aspirin (an antiplatelet) . She verbally confirmed Clopidogrel was an antiplatelet and should not have been coded as an anticoagulant. She revealed she did not know Aspirin was an antiplatelet but should have been coded as an antiplatelet. The MDS nurse stated the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18. 11, October 2023, revealed, N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).</p> <p>2. Record review of Resident #9's face sheet, dated 09/11/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: type 2 Diabetes mellitus (high level of sugar in the blood), muscle wasting and atrophy (muscles to decrease in size and strength), chronic kidney disease stage 3 (kidney damage unable to filter waste from the blood), hypertension (high blood pressure), and cerebral infarction (low blood flow to the brain).</p> <p>Record review of Resident #9's annual MDS assessment, dated 03/22/2024, indicated her BIMS score was 15 of 15 reflecting she was cognitively intact. Further record review indicated the question of J1300: Current tobacco use in the Section J (Health Conditions) was answered No.</p> <p>Record review of Resident #9's comprehensive care plan, dated initiated 10/08/2020, reflected [Resident #9] is a smoker, and the intervention was instruct resident about smoking risks and hazards and about smoking cessation aids that are available.</p> <p>Record review of Resident #9's smoking assessment, dated 03/15/2024, reflected Resident #9 was a smoker and smoking at the facility smoking area under supervision.</p> <p>Observation on 09/11/2024 at 11:00 a.m. indicated Resident #9 was smoking at the facility smoking area under supervision.</p> <p>Interview on 09/08/2024 at 3:34 p.m. with Resident #9 revealed the resident had been smoking cigarettes for long time, and five times a day at the facility smoking area.</p> <p>Interview on 09/11/2024 at 10:39 a.m. with MDS nurse-AG acknowledged Resident #9's annual MDS dated [DATE]'s question of Current tobacco use in the Section J (Health Conditions) was answered No, and it was mistake because Resident #9 had been smoking since she was admitted to the facility. Further interview with the MDS nurse revealed the question of current tobacco use should have been answered Yes, MDS nurse had responsibility for accurate MDS, and the potential harm was an inaccurate MDS might cause incorrect care to the resident.</p> <p>Interview on 09/11/2024 at 1:03 p.m. with the DON revealed the facility did not have the policy regarding MDS accuracy. The facility was following CMS MDS 3.0 Manual.</p> <p>Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18. 11, October 2023, revealed, N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .  39049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder for level II resident review for 1 (Resident #68) of 18 residents reviewed for resident assessments.</p> <p>The facility failed to refer Resident #68 for re-evaluation of PASARR level I review following a diagnosis of schizoaffective disorder-bipolar type, added on 01/05/2024.</p> <p>This failure could place residents at risk of not having their mental health needs met by the facility and could place all residents at risk of harm by mentally unstable residents.</p> <p>Findings Included:</p> <p>Record review of Resident #68's face sheet, dated 09/10/2024, revealed the resident was [AGE] years old male and an admitted [DATE] with diagnoses that included: cirrhosis of liver (scar tissue replaces healthy liver tissue), hypertension (high blood pressure), atherosclerotic heart disease (plaque buildup in artery walls), and schizoaffective disorder-bipolar type (chronic mental illness that causes symptoms of both schizophrenia and a mood disorder).</p> <p>Record review of Resident #68's quarterly MDS assessment completed on 08/16/2024 Section C revealed a BIMS score of 10 which indicated moderate cognitive impairment. Section I (Active diagnoses) indicated Resident #68 had diagnoses of Schizophrenia (schizoaffective and schizophreniform disorders). Section N (Medications) indicated Resident #68 was taking antidepressant and antipsychotic medications.</p> <p>Record review of Resident #68's care plan, dated 05/27/2024, revealed Resident #68 had the potential to be physically aggressive related to schizoaffective disorder-bipolar type. He was receiving antidepressant and antipsychotic medications, and the interventions were Monitoring behaviors, notify medical doctor of new or worsening behaviors, and monitor/document/report as needed for any adverse reactions.</p> <p>Record review of Resident #68's diagnosis report, dated 01/05/2024, revealed the diagnoses of schizoaffective disorder-bipolar type had an onset date of 01/05/2024.</p> <p>Record review of Resident #68's physician order, dated 01/05/2024, revealed the physician prescribed Zyprexa 5 mg every day at hour of sleep by mouth for schizoaffective disorder-bipolar type. Further record review revealed Resident #68's physician increased Zyprexa from 5 mg to 10 mg.</p> <p>Record review of Resident #68's medical record from 01/05 2024 to 09/11/2024 revealed there was no referral to a local authority regarding re-evaluation of PASARR by the resident's new mental status (new diagnosis of schizoaffective disorder-bipolar type).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/10/2024 at 11:50 a.m. with the DON revealed if a resident came from a home, the facility had the responsibility to conduct the PASARR evaluation, but if a resident came from an acute hospital, the hospital had responsibility to conduct PASARR evaluation. Resident #68 came from an acute hospital on 11/08/2021 with a negative result of PASARR Level I evaluation, and the facility just followed the evaluation.</p> <p>Interview on 09/10/2024 at 11:58 a.m. with MDS Coordinator-AF and MDS nurse-AG revealed because Resident #68 received a new diagnosis of schizoaffective disorder-bipolar type and taking antipsychotic medication (Zyprexa) on 01/05/2024, the facility should have referred Resident #68 to a local authority because Resident #68 had a significant change in his mental status assessment. Further interview with two nurses revealed they started working as MDS nurses in three months. They did not know what reason the facility did not refer Resident #68 to a local authority for re-evaluation of PASARR. MDS nurses had responsibility for re-evaluating residents regarding changing of condition, and the potential harm was Resident #68 might not receive PASARR benefits that he should take.</p> <p>Interview on 09/11/2024 at 1:03 p.m. with DON stated the facility did not have the policy regarding PASARR re-evaluation. The facility was following CMS regulations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</b></p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 18 residents (Resident #17) reviewed for comprehensive care plans, in that:</p> <p>The facility failed to ensure Resident #17, who was always incontinent of bladder and bowel, had a care plan regarding bowel incontinence care.</p> <p>This deficient practice could place residents at risk for not receiving proper care and services.</p> <p>The findings included:</p> <p>Record review of Resident #17's face sheet, dated 09/11/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Dementia (decline in cognitive ability), major depressive disorder (loss of interest in activities), hypertension (high blood pressure), muscle wasting and atrophy (muscles to decrease in size and strength), and chronic kidney disease (kidney damage unable to filter waste from the blood).</p> <p>Record review of Resident #17's quarterly MDS assessment completed on 08/07/2024 Section C (Cognitive Patterns) revealed a BIMS score of 03which indicated severe cognitive impairment. Section GG (Functional Abilities and Goals) indicated Resident #17 required substantial/maximal assistance (helper dose more than half the effort) to toilet hygiene, sit to stand, chair/bed-to-chair transfer, and not attempted due to medical condition or safety concern to toilet transfer. Section H (Bladder and Bowel) indicated Resident #17 was always incontinent to bladder and bowel.</p> <p>Record review of Resident #17's care plan, date revised 02/10/2023, revealed Resident #17 had problem: the resident has bladder incontinence, and interventions: clean peri-area with each incontinence episode, encourage fluids during the day to promote prompted voiding responses, and ensure the resident had unobstructed path to the bathroom. Further record review of the resident care plans indicated no care plans regarding bowel incontinence.</p> <p>Interview on 09/10/2024 at 2:25 p.m., CNA-AH acknowledged Resident #17 was always bowel incontinent, so CNAs checked the resident every 2 hours and provided bowel incontinent care.</p> <p>Interview on 09/10/2024 at 2:28 p.m., MDS Coordinator RN-AF acknowledged Resident #17 was always bowel incontinent and needed to have a care plan for bowel incontinence. However, Resident #17's care plan addressed only bladder incontinence. There was no a care plan regarding bowel incontinent care. Further interview with MDS Coordinator RN-AF revealed they did not know what reason Resident #17's bowel incontinence care plan was missing because they were hired three months ago. MDS nurse had responsibility for care plan, and the potential harm was the resident might have skin breakdown because of a lack of care by no care plans.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/11/2024 at 1:03 p.m. with the DON Was revealed the facility did not have the policy regarding care plan. The facility was following CMS regulations.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34957</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #54) reviewed for quality of care.</p> <p>The facility failed to ensure Resident #54 was properly secured in the facility transport van on 08/22/24 and sustained a fall resulting in fractures to the third and fourth left hand fingers and a fracture to the right elbow.</p> <p>The noncompliance was identified as PNC. The IJ began on 08/22/204 and ended on 08/24/2024. The facility had corrected the noncompliance before the survey began.</p> <p>Assessment of Resident #54.</p> <p>Inservice training to all staff related to Abuse and Neglect and Reporting Incidents to MD and RP.</p> <p>Van safety training with 7 van drivers to include proper use of van lift and proper ways to secure residents in wheelchairs.</p> <p>Safe surveys with 48 residents using facility transportation.</p> <p>Termination of Van Driver AL (responsible for the incident) post facility investigation.</p> <p>This failure could place residents who use wheelchairs and access the facility's van for transport, at risk for accidents resulting in serious injury, serious impairment, or death.</p> <p>The Findings were:</p> <p>Record review of Resident #54's EMR revealed: the resident was a [AGE] year-old female who admitted on [DATE] (initial 9/9/2022) with diagnoses that included: Metabolic encephalopathy (brain disorder), seizures, Acute kidney failure, Type 2 DM (diabetes), Anxiety, Dementia, Aphasia (language disorder that affects the resident's ability to communicate, for instance, resulting from a stroke. Dysphagia (difficulty swallowing), Traumatic subarachnoid hemorrhage (5/19/2020) (brain bleed) . RP was listed as a family member. BIMS score dated 8/22/24 was 03 (severely impaired) WC bound for transport.</p> <p>Record review of Resident #54's Quarterly MDS assessment dated [DATE] revealed: resident was dependent on transfers and transportation.</p> <p>Record review of Resident #54's Physician orders dated September 2024 reflected: Pain medications regiment in place, Depakote for seizures [evidence revealed that the resident did not have a seizure in the van]. Resident on aspirin and Plavix increasing her risk for bruising and bleeding.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #54's EMR revealed the timeline for the incident on 8/22/24 was: 8/22/24 resident had appointment on 8/22/24 at 3:00 PM at a local clinic and fell in the van on the way to the clinic. [Record review of Nurse Note] Resident #54 returned to the facility at 5:00 PM. At 5:21 PM resident showed signs of redness. At 8:47 PM, pain present and resident sent to ER. Resident returned on 8/23/24 at 54 AM. On 8/23/24 the resident was sent back to the MD clinic for follow-up for the x-ray fracture results. MD AO resend the resident to the ER for a re-evaluation and possible admissions. The Resident returned to the facility on [DATE] at 2:45 PM.</p> <p>Record review of Intake #526868 reflected: On 8/23/24 resident [#54] attended a doctor's appointment, transported by our facility van. Resident returned to facility with redness to right side of face. As per Van Driver [AL] van door closed on resident hitting her face. Resident developed more discolorations and was sent to Emergency Dept. X-ray findings [ Closed nondisplaced fracture of proximal phalanx of the ring finger, head of rt. radius, proximal of left middle finger.]</p> <p>Record review of Resident #54's Fall risk assessment on 08/22/24 showed the resident to be at high risk for falls.</p> <p>Record review of Resident #54's nursing assessment on 8/22/24 at 8:47 AM reflected: resident had no pain, skin intact and able to move all extremities. Discoloration to left hand 2nd digit, left lower leg right upper eyelid, right cheek, right upper arm, right knee.</p> <p>Record review of Resident #54's hospital record dated 8/22/24 reflected: X-ray findings closed non-displaced fracture of proximal (closer) phalanx (bone) of the ring finger, head of right radius (elbow), proximal of left middle finger.</p> <p>Record review of Resident #54's Nurse Progress Notes reflected:</p> <p>8/22/2024 17:21 [5:21 PM] NURSING - Nurse Note</p> <p>Note Text: Upon Head-to-toe assessment minimal swelling to right side of face, discoloration redness in color noted to upper eyelid, skin intact, redness discoloration to lateral side of right elbow, skin intact, resident able to move upper extremities, with no discomfort noted, minimal swelling and discoloration to left middle finger, abrasion to right knee noted, resident able to move lower extremities as tolerated. MD [AO] notified. Assisted resident to dining room for dinner. Signed by LVN [AM].</p> <p>8/22/2024 17:20 [5:20 PM] NURSING - Nurse Note Text: Notified by transportation aide [Van Driver AL] that resident [Resident #54] got hurt by the door of the facility van. Resident going to appointment, transportation aide notified Doctor {MD AO} of incident, no new orders written on communication sheet. Resident laughing stated I don't have pain I want water. Face assessed noticed redness, swelling and right side of face, bump on forehead and small skin tear approximately 1 cm x 1 cm on right eye. resident denies pain or discomfort, resident in dining area having cup of water and waiting for supper. BP (blood pressure):135/95 P (pulse):98 R (respiration):16 T (temperature): 98.5 o2 (oxygen): 96% room air . unable to contact, incoming nurse made aware to follow up. Neurochecks initiated. Signed by LVN [AM].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>8/23/2024 05:5 NURSING - Nurse Note Text: Resident [#54] return from ER resident in bed at lowest position, v/s (vital signs) taken and wnl. [with normal limits] Resident sleeping does not display signs of pain or discomfort. DON MD [AO] AND RP notified. New Order: F/U (follow up) with orthopedic [MD AP] to 3rd and 4th finger I-hand signed LVN [AM].</p> <p>Record review of written statement from Van Driver AL reflected: 8/23/24: he admitted the resident [Resident #54] had sustained a fall in the Van. Van Driver AL stated, Resident fell on her knees then on her right side. Van Driver AL assisted the resident back to her w/c and went to PCP appointment. The straps were noted in place, the seat belt was noted loose. The resident was assessed at the MD appointment and no injury were noted at the time.</p> <p>Observation and interview on 9/9/24 at 8:29 AM [witnessed by CMA AJ per resident's request], revealed Resident #54 was in her room lying in bed attempting to sleep, the resident was alert and oriented to person and place. Further observation of the resident revealed: fading bruise color blue/yellow to right side of face and right hand bandaged with middle and ring finger purple discoloration with a finger brace. The resident grimaced. Call light was in reach; room was cleaned; there were no fall hazards; and the room was homelike. The Resident stated that she fell in the van on the right side and suffered pain. The resident stated that the WC fell with her during the fall in the van. The resident could not remember the date of the fall in the van. The resident stated that the driver pushed the breaks hard which resulted in the fall. The resident did not provide other details involving the fall.</p> <p>During an interview on 09/09/24 11:04 AM CMA AJ stated the resident said, she was in the van with a strap on her upper body sitting on a WC .the WC fell to the right side .and that she had pain in the left hand .and that she had fallen.</p> <p>Record review of facility's investigation file, after the incident, revealed the following interventions:</p> <p>Observation and interview with residents on abuse and neglect. [interview sheets]</p> <p>In-service for all staff on abuse and neglect [98 staff with a completion rate of 100%] Training completed 8/24/24. [signature sheets]</p> <p>Head to toe assessment completed on Resident #54, MD AO and RP notified of the incident. [skin assessment]</p> <p>Van Driver AL suspended [and eventually terminated] [termination form]</p> <p>Facility van grounded until all 7 van drivers were certified on van safety by an outside contractor. [certification sheet]</p> <p>Future medical transport for Resident #54 would be by contracted van stretcher. [progress note]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Facility's Safe surveys dated 8/23/24 were completed on the residents [48 resident eligible for transport] that have been transported by the van driver and no negative findings. [safety survey sheets]</p> <p>Self-report to HHS was submitted and the facility' finding was inconclusive. [5-day report]</p> <p>Record review of Driver evaluation [Van Driver AL] road test form revealed completion on 8/28/24.</p> <p>Record review of facility's investigation file dated on 8/23/24 reflected: Van Driver AL was asked for statement on incident and stated that resident had fall in van. [Van Driver AL stated Resident #54 hit her hand on the van door.]</p> <p>Record review of Van Driver AL employee filed revealed:</p> <p>Current driver's license.</p> <p>Counseling form dated 9/3/24 with termination of employee for not providing correct information on the incident on 8/22/24.</p> <p>Completion on 7/4/24 of Strategies for Transporting Passengers continuing education.</p> <p>Completion on 1/9/24 of Safe Lifting continuing education.</p> <p>Van Driver Job Description undated reflected: Assist residents .in and out of the vehicle .Perform pre-trip inspections .</p> <p>Completion of Driver's Orientation Checklist dated 1/17/23 which included: Wheelchair lifts &amp; restraints .</p> <p>Completion of Abuse and Neglect training on 8/11/24.</p> <p>No negative information on the EMR 2 (2024) and Criminal History Check (1/16/2023)</p> <p>Observation on 9/9/24 at 12:30 PM of van safety revealed Van Driver AK properly demonstrated the lifting of the WC from the back door and securing the WC with anchors and safety belt and harness strap. Van Driver AK stated she received training on the proper securing of residents with WCs in a van.</p> <p>During an interview with the facility's Maintenance Supervisor on 9/9/24 at 12:35 PM, he stated he could not explain how Resident #54 injured herself on 8/22/24 except that she was not properly secured in the van. The Maintenance Supervisor stated that after the accident a contracted company gave the van drivers [total of 7] instruction on the proper securing of a WC. The Maintenance Supervisor stated since the accident on 8/23/24 there had been no other accidents in the van. The Maintenance Supervisor stated that, monthly, he checked on van safety especially on the proper securing on residents with wheelchairs; and checked periodically.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/9/24 at 12:40 PM, the Administrator stated there was confusion over how the injury on 08/22/24 occurred in the van. The Administrator stated that Van Driver AL changed the incident from the resident striking her finger on the door to the resident having a loose safety belt. The Administrator stated Van Driver AL was terminated for not providing the correct information involving the incident on 8/22/24. The Administrator stated that the Resident #54 likely suffered an injury to the hand due to a loose safety belt/ shoulder strap. The Administrator stated that after the incident the van drivers, a total of seven, were in-serviced by an outside contractor on van safety and the proper securing of a WC.</p> <p>During a telephone interview on 9/9/24 at 1:02 PM, (former) Van Driver AL stated he was taking the Resident #54 to a PCP and had to push the breaks hard to avoid a car accident. Van Driver C stated, Resident #54 fell forward first on her knees and then to her face; the WC did not fall with the resident. Van Driver AL stated that he had secured the seat belt prior to the trip to the PCP. Van Driver AL stated that the seat belt/shoulder strap was likely loose prior to the accident. Van Driver AL stated that he should have checked the tightness of the seat belt/ shoulder strap prior to embarking on the trip to ensure safety of the resident passengers.</p> <p>During a joint interview on 9/9/24 at 1:16 PM, Van Driver AQ and Van Driver AR stated the highlights of the in-service received two weeks ago by an outside vendor [8/23/24-8/28/24] included: van safety, proper securing of WC from start to finish involving a resident; and double checking the proper fitting of the seat belt and shoulder strap prior to leaving on a trip for the residents.</p> <p>During an interview on 9/9/24 at 1:33 PM, LVN AM stated on 8/22/24 Resident #54 returned from her appointment and she LVN D saw her face (Resident #54) and it was red with minimal swelling. LVN AM stated she inquired of Van Driver [AL] and he stated that the van door hit the resident on the right side. LVN AM stated that a bruise was developing, and Van Driver AL again said the door hit her hand. LVN AM stated the resident had no pain. LVN AM did a full assessment in the evening around 8:00 PM and the resident face revealed a bruise. LVN AM stated that the DON spoke to the MD [AO] and decision was made to refer the resident to the ER. LVN AM stated, we later found out the resident had a fracture to the third and fourth left fingers and right elbow fracture. LVN AM stated she received an in-service on van safety on 8/24/24.</p> <p>During an interview on 9/10/24 at 8:30 AM, the DON stated that Resident #54 did not ride the van for medical appointments. The DON stated Resident #54 was transported by a contracted van stretcher company for medical appointments.</p> <p>During a joint interview on 9/10/24 at 9:55 AM, the Administrator and DON stated the only 7 certified van drivers were allowed to transport residents in the facility's van and no other staff. The Administrator stated that the 7 current van drivers were trained and certified on van safety and the proper securing of a WC and seat/harness in the facility van.</p> <p>Observation on 9/10/24 at 12:01 PM of van safety procedures revealed, Van Driver AK properly secured Resident# 52 on the van lift, anchored the WC in the van, and checked the seat belt and shoulder strap; no deficiencies or violations were noted.</p> <p>Observation on 9/10/24 at 1:30 PM of van safety procedures revealed, Van Driver AK properly removed Resident #52 with WC from the van with no incidents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of facility's grievance log for the past 6 months (February 2024-September 2024) revealed no grievances filed involving van safety.</p> <p>Record review of in-service certification conducted on 8/27/24 on van safety for 7 van drivers was done by an outside transportation contractor.</p> <p>Record review of in-service training on the topics of van safety, fall prevention, and van safety was given to all staff from 8/23/24 to 8/27/24.</p> <p>Record review of facility's Fall Prevention Program undated revealed: one was present an in-effect. [the policy did not address van safety techniques or procedures].</p> <p>During the exit conference on 9/11/24 at 2:00 PM, the Administrator and the DON were informed that evidence revealed a past non-compliance IJ (immediate jeopardy) for inadequate supervision of Resident #54 on 8/22/24.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications from enteral feeding for 1 (Resident #79) of 3 residents reviewed for quality of care.</p> <p>The facility failed to ensure Resident #79, who was receiving Glucerna at a rate of 55 ml/hour via tube feeding on 09/08/2024, coincided with the physician order that indicated providing Glucerna at a rate of 60 ml/hour to the resident.</p> <p>This failure could place residents at risk of not receiving the proper tube feeding requirements prescribed by the physician.</p> <p>Findings included:</p> <p>Record review of Resident #79's face sheet, dated 09/08/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Dementia (decline in cognitive ability), surgical aftercare following surgery on the digestive system, dysphagia (swallowing difficulties), muscle wasting and atrophy (muscles to decrease in size and strength), hypertension (high blood pressure), and type 2 Diabetes mellitus (high level of sugar in the blood).</p> <p>Record review of Resident #79's quarterly MDS assessment completed on 06/17/2024 Section C (Cognitive Patterns) revealed a BIMS score of 00 which indicated severe cognitive impairment. Section GG (Functional Abilities and Goals) indicated Resident #79 required dependence (full staff performance every time) for chair/bed-to-chair transfer and eating. Section K (swallowing/nutritional status) indicated Resident #79 had a feeding tube.</p> <p>Record review of Resident #79's care plan, date revised 03/05/2024, revealed Resident #79 had problem: the resident requires tube feeding related to dysphagia, and interventions: the resident needs total care with tube feeding and water flushes. See medical doctor orders for current feeding orders.</p> <p>Record review of Resident #79's physician order, dated 09/04/2024, revealed Enteral feed order - every shift Glucerna 1.5 at 60 ml/hour x 18 hours via gastrostomy tube stationary pump.</p> <p>Observation on 09/08/2024 at 11:11 a.m. revealed Resident #79 was on the bed and receiving Glucerna 1.5 via gastrostomy tube stationary pump, and the rate was set up at 55ml/hour on the pump machine.</p> <p>Interview on 09/08/2024 at 11:28 a.m., LVN-AI acknowledged Resident #79 was receiving Glucerna 1.5 with the rate of 55 ml/hour via tube feeding pump, but the physician order indicated providing Glucerna 1.5 with the rate 60 ml/hour to the resident. LVN-AI stated Resident #79's physician increased the rate from 55 ml/hour to 60 ml/hour on 09/04/2024, but the nurse forgot it and set the rate to 55 ml/hour. The potential harm was Resident #79 might not have enough calories and could have weight loss.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/10/2024 at 4:20 p.m. with the DON revealed Resident #79 should have been receiving Glucerna 1.5 with the rate of 60 ml/hour via tube feeding pump, instead of 55 ml/hour because the physician gave the order of 60 ml/hour on 09/04/2024. Nurses should follow physician orders, and the potential harm was the resident could have weight loss.</p> <p>Record review of the facility's policy, titled Medication Administration, including tube feeding, dated 10/24/2022, revealed Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state as ordered by the physician in accordance with professional standards of practice. 14. Administer medication as ordered in accordance with manufacturer specifications.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 2 residents (Residents #63) reviewed for quality of care in that:</p> <p>The facility failed to ensure Resident #63's nebulizing mask and tubing, that were observed on 09/08/2024, were not covered in a plastic bag dated on 07/21/2024.</p> <p>This failure could affect residents who received nebulizing treatment and place them at risk for respiratory infections.</p> <p>The findings included:</p> <p>Record review of Resident #63's face sheet, dated 09/09/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Alzheimer's disease (damages memory and thinking skills), hypertension (high blood pressure), muscle wasting and atrophy (muscles to decrease in size and strength), dysphagia (swallowing difficulties), and cardiac arrhythmia (irregular heartbeat).</p> <p>Record review of Resident #63's quarterly MDS assessment with an ARD of 07/26/2024 reflected the resident scored an 00 on her BIMS which signified the resident had severe cognitive impairment, and the resident needed to have substantial/maximal assistance (helper dose more than half the effort) to eating, shower/bathing, and dressing, but not attempted due to medical condition or safety concern to toilet and sit to stand transfer.</p> <p>Record review of Resident #63's physician orders, dated 07/20/2024, reflected Albuterol Sulfate Nebulization Solution 2.5 mg/0.5 ml one (1) application inhale orally via nebulizer every 4 hours as needed for congestion.</p> <p>Observation on 09/08/2024 at 10:22 a.m. revealed Resident #63's nebulizer was on the nightstand connected to tubing and mask. The tubing and mask were covered in a plastic bag. The mask was dated on 07/21/2024.</p> <p>Observation and interview on 09/08/2024 at 10:28 a.m. with LVN-AI, revealed she saw Resident #63's tubing and mask and acknowledged the tubing and mask connected to Resident #63's nebulizer were covered in a plastic bag, and the mask was dated on 07/21/2024. LVN-AI stated Resident #63 sometimes used the nebulizer and mask for breathing treatments. LVN-AI stated, per the facility policy, nurses should have changed the tubing and mask for breathing treatments weekly, and LVN-AI did not know why nurses did not change them weekly. The potential harm was Resident #63 might have respiratory infection due to old tubing and mask.</p> <p>Interview on 09/09/2024 at 5:26 p.m. with the DON revealed facility nurses should have changed Resident #63's tubing and mask for breathing treatment weekly. The potential harm was the resident could have respiratory infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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 0695  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Record review of the facility's policy, titled Small Volume Nebulizer, undated, reflected . 10. Assemble small volume nebulizer and label with the date the nebulizer was set up. Nebulizers are to be changed after 7 days of use.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39049</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that:</p> <p>The facility failed to ensure three packets of bread, observed in the freezer on 09/08/2024, were labeled and dated, and that one of packets was not opened in the freezer because the plastic bag was torn.</p> <p>This failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 09/08/2024 at 9:59 a.m. in the kitchen revealed there was one freezer in the dry storage room, and inside the freezer there were three packets of bread. Two packets were covered in plastic bags but not labeled and dated. The other packet was French toasted bread, covered in a plastic bag, but the packet was opened because the plastic bag was torn. The packet of French toasted bread was also not labeled and dated.</p> <p>Interview on 09/08/2024 at 10:01 a.m., Kitchen Supervisor-N saw the three packets of bread inside the freezer located in the dry storage room and acknowledged the three packets of bread were not labeled and dated, and the French toasted bread was opened in the freezer because the plastic bag was torn. The kitchen supervisor stated she did not know when they were opened, and the staff should have labeled and dated on the packets and changed the torn plastic bag to new one to prevent food infection.</p> <p>Interview on 09/10/2024 at 12:40 p.m. with Registered Dietitian-Y revealed kitchen staff should have labeled and dated on the packets and changed the broken plastic bag to a new one for food safety. The potential harm was residents might have gotten food poison.</p> <p>Record review of the facility's policy, titled Food Storage, date revised 06/01/2019, revealed To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines, and Freezer . e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 6 residents (Residents #83 and #63) reviewed for infection control, in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure CNA AD used the proper technique to sanitize her hands while providing incontinent care for Resident #83.</li> <li>2. The facility failed to ensure CNA-AD and CNA-AE wore a gown while performing incontinent care for Resident #63 who was on EBP (Enhanced Barrier Precautions) on 09/10/2024.</li> </ol> <p>These deficient practices could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #83's face sheet, dated 09/10/2024, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses which included: Dementia (decline in cognitive abilities), Epilepsy (Neurological disorder characterized by seizures) and History of traumatic brain injury (Injury to the brain caused by an external force).</li> </ol> <p>Record review of Resident #83's Quarterly MDS assessment, dated 07/05/2024, revealed Resident #83 had a BIMS score of 7, which indicated severe cognitive impairment. Resident #83 was indicated to always be incontinent of bowel and bladder. He required extensive assistance with his ADLs.</p> <p>Record review of Resident #83's care plan, dated 07/24/2024, revealed a problem of SKIN INTEGRITY: The resident is at risk for impaired skin integrity related to: Braden score indicating moderate risk, liver d disease, incontinence of bowel and bladder, with a goal of The resident will remain free from alterations in skin integrity.</p> <p>Observation on 09/10/2024 at 11:00 a.m. revealed while providing incontinent care for Resident #83 CNA AD changed her gloves and used sanitizer but did not rub the sanitizer between her fingers.</p> <p>During an interview on 09/10/2024 at 11:10 a.m. CNA AD confirmed she should have rub the sanitizer between her fingers to sanitize the entire surface of her hands. She forgot. She confirmed receiving infection control and hand washing training within the year</p> <p>During an interview with the DON on 09/10/2024 at 11:20 a.m., the DON confirmed that the correct technique to use sanitizer was to sanitize the whole hand, including between the fingers. The DON revealed improper hand hygiene could present a risk of infection by cross contamination for the residents. The facility was doing annual infection control and incontinent care training and annual skills checks.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy, titled Hand Hygiene, dated 10/24/2022, revealed Hand hygiene technique when using an alcohol-based hand rub:</p> <p>a. Apply to palm of one hand the amount of product recommended by the manufacturer.</p> <p>b. Rub hands together, covering all surfaces of hands and fingers until hands feel dry.</p> <p>c. This should take about 20 seconds.</p> <p>2. Record review of Resident '63's face sheet, dated 09/09/2024, revealed the resident was [AGE] years old female and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Alzheimer's disease (damages memory and thinking skills), hypertension (high blood pressure), muscle wasting and atrophy (muscles to decrease in size and strength), dysphagia (swallowing difficulties), and cardiac arrhythmia (irregular heartbeat).</p> <p>Record review of Resident #63's quarterly MDS assessment with an ARD of 07/26/2024 reflected the resident scored a 00 on her BIMS which signified the resident had severe cognitive impairment, and the resident needed to have substantial/maximal assistance (helper does more than half the effort) for eating, showering/bathing, and dressing, but not attempted due to medical condition or safety concern to toilet and sit to stand transfer.</p> <p>Record review of Resident #63's care plan, date initiated 07/16/2021, revealed problem: the resident has bladder incontinence related to Alzheimer's disease, and intervention: Brief use - the resident uses disposable briefs. Change every 2 hours and as needed.</p> <p>Observation on 09/10/2024 at 8:42 a.m. indicated there was a sign on the door of Resident #63's room, and the sign said Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care) and observed a container with three compartments for gown and gloves in front of Resident #63's room.</p> <p>Observation on 09/10/2024 at 8:43 a.m. indicated CNA-AD and CNA-AE put on only gloves after washing their hands, entered to Resident #63's room, and provided incontinent care to Resident #63 without putting on a gown.</p> <p>Interview on 09/10/2024 at 8:58 a.m., CNA-AD and CNA-AE acknowledged they did not put on a gown when they provided incontinent care to Resident #63 and stated they should have put on a gown when providing incontinent care because Resident #63 was on EBP, and incontinent care was one of the high-contact resident care activities. They were nervous so they forgot to put on a gown. The potential harm was Resident #63 could have infections.</p> <p>Interview on 09/10/2024 at 4:20 p.m. with the DON revealed CNA-AD and CNA-AE should have put on a gown when providing incontinent care because Resident #63 was on EBP, and incontinent care was one of the high-contact resident care activities. The potential harm was Resident #63 might be infected.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Maverick Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3106 Bob Rogers Dr Eagle Pass, TX 78852	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy, titled Enhanced Barrier Precautions, dated 04/05/2024, revealed It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multiple-resistant organisms. Enhanced Barrier Precaution (EBP) refers to an infection control intervention designed to reduce transmission of multiple-resistant organism that employes targeted gown and gloves use during high contact resident care activities. 4. High-contact resident care activities include: F. Changing briefs or assisting with toileting.</p> <p>39049</p>		