

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Midland Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Mockingbird LN Midland, TX 79705	

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 - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 45411</p> <p>Based on interview and record review, the facility failed to ensure an accurate MDS was completed for 3 of 22 residents (Residents #33, #37, and #41) reviewed for MDS assessment accuracy.</p> <ol style="list-style-type: none"> 1. The facility failed to accurately address Resident #33's tracheostomy status on her Quarterly MDS assessment. 2. The facility failed to accurately address Resident #37's use of insulin on her Quarterly MDS assessment. 3. The facility failed to accurately address Resident #41's dependence on dialysis on her Admission MDS assessment. <p>The failures could place residents at risk for not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Resident #33</p> <p>Review of Resident #33's Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with admitting diagnoses which included quadriplegia (paralysis of all four limbs), tracheostomy status (an opening surgically created through the neck into the windpipe to allow air flow into the lungs), and chronic respiratory failure.</p> <p>Review of Resident #33's Order Summary Report dated 7/2/24 revealed the following:</p> <p>Change inner cannula Shiley #6 everyday (one time a day for Trach use) Order Date 3/23/21</p> <p>Clean Trach Collar (at bedtime) Order Date 3/23/21</p> <p>Trach - Change Inner Cannula = Change the disposable inner cannula of trach as needed, using sterile technique. Document any adverse reaction (as needed) Order Date 3/23/21</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clean Inner Cannula Every Shift & PRN (every shift AND every 8 hours as needed) Order Date 3/23/21</p> <p>Trach Care: Change Nebulizer Tubing, Trach Collar Every Week (every night shift, every Sun) Order Date 3/28/21</p> <p>Trach - Supply Check = Check every shift to ensure the following supplies are at bedside: Extra trach, suction machine, suction catheters, ambu-bag, humidified oxygen (every shift) Order Date 3/23/21</p> <p>Trach -Suction PRN= May suction as needed, using sterile technique. Document character of secretions (as needed) Order Date 3/23/21</p> <p>Trach Care: Trach care every shift and PRN using sterile technique (every shift AND as needed) Order Date 3/22/21</p> <p>Trach Dressing Change = Change trach dressing every day and PRN, using sterile technique. Document any adverse conditions/reactions (every day shift AND as needed) Order Date 3/22/21</p> <p>Review of Resident #33's Quarterly MDS assessment dated [DATE] revealed she was unable to complete a mental status evaluation due to her impaired cognition. She was dependent on staff for all ADL's. Her active diagnoses list included her tracheostomy status, however Section O - Special Treatments, Procedures, and Programs did not address Resident #33's tracheostomy care or suctioning.</p> <p>Review of Resident #33's Care Plan, most recent revision date 5/24/24, revealed the following:</p> <p>Problem - Trach Care: Resident has a history of infection of the trach R/T family touching trach area without gloves.</p> <p>Goal - The resident will be free from complications related to infection through the review date.</p> <p>Interventions - 3/22/2021 Change trach dressing every day and PRN, using sterile technique. Document any adverse conditions/reactions. 3/22/2021 Trach Care: Trach care every shift and PRN using sterile technique. 3/23/2021 Change Nebulizer Tubing, Trach collar every week (night shift, every Sunday). 3/23/2021 May suction as needed, using sterile technique. Document character of secretions. 4/13/2021 Clean trach collar at bedtime. Duo-neb solution four times a day r/t chronic respiratory failure. Follow facility policy and procedures for line listing, summarizing, and reporting infections. Lung/Respiratory Assessments every shift. Record vitals and number for lung sounds present; along with total minutes spent with pt. during assessment. Maintain universal precautions when providing resident care. Monitor temperature/pulse per MD orders. Mucinex fast max dm liquid via peg two times a day. Repeat sputum culture with sensitivity CBC, CMP in a.m.</p> <p>Problem - resident has a tracheostomy r/t Impaired breathing mechanics.</p> <p>Goals - The resident will have clear and equal breath sounds bilaterally through the review date. The resident will have no s/sx of infection through the review date. The resident will have no abnormal drainage around trach site through the review date.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interventions - 3/22/2021 Flonase Suspension 50 MCG/ACT (Fluticasone Propionate) 1 spray in both nostrils one time a day related to OTHER SEASONAL ALLERGIC RHINITIS (J30.2). 3/22/2021 Lung/Respiratory Assessment- Assess Lungs & Sounds Present - Vital Signs - Check Time Prior to Assessment and Again After Completion to Track total Minutes Spent Performing Assessment. 3/22/2021 Mucinex Fast-Max DM Max Liquid 20-400 MG/20ML (Dextromethorphan-guaifenesin) Give 20 ml via PEG-Tube two times a day for Medical Diagnosis/Condition related to OTHER SEASONAL ALLERGIC RHINITIS (J30.2) CHANGED ON 8/23/2021 every 12 hours prn congestion.</p> <p>4/04/22 Atropine Sulfate Solution 0.01 % Give 1 drop sublingually every 4 hours as needed for excess secretions related to ENCOUNTER FOR ATTENTION TO TRACHEOSTOMY (Z43.0) 4/04/22 Chest X-ray one time only for rule out aspiration/pneumonia related to CHRONIC RESPIRATORY FAILURE, UNSPECIFIED WHETHER WITH HYPOXIA OR HYPERCAPNIA (J96.10) for 1 Day. 4/8/24 EBP implemented due to at risk for infection. 6/07/22 Refer to ENT for trach evaluation and replacement if needed. Resident to ER for bleeding noted when suctioning and resident told ER they had put in the wrong trach and ER referred her to ENT. Change inner cannula Shiley #4 every day one time a day for trach use change outer trach dressing every shift and PRN. Clean inner cannula every shift and prn. Clean trach collar one time a day. Duo-Neb Solution (Ipratropium-Albuterol) per MD orders. Elevate HOB at least 30 degrees every shift. Keep lips moist all the times every shift. Monitor/document for restlessness, agitation, confusion, increased heart rate (Tachycardia), and bradycardia. Monitor/document level of consciousness, mental status, and lethargy PRN. Monitor/document respiratory rate, depth, and quality. Check and document every shift/as ordered. Nebulizer treatment of albuterol as ordered by MD. Document v/s, lung sounds, and minutes spent prior to and after administration. OXYGEN SETTINGS: 2-5 l/m via trach prn to keep sats >92%, check o2 sats every shift and as needed. Provide good oral care daily and PRN. RESPIRATORY THERAPY: Assess Shortness of Breath; Assess bed positioning related to SOB, specifically when lying flat(orthopnea); Assess for cough and sputum production and character; Assess for signs/symptoms of worsening lung function; Assess lung sounds and describe type and location of abnormal sounds; Assess vital signs and respiratory effort; Describe all breathing/respiratory exercises performed this shift; Describe all Education provided this shift; Document time spent with resident in respiratory assessment, monitoring and treatment. Suction as necessary. trach care every shift and PRN. May use trach mask prn. TUBE OUT PROCEDURES: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help IMMEDIATELY. Use UNIVERSAL PRECAUTIONS as appropriate.</p> <p>Resident #37</p> <p>Review of Resident #37's Admission Record dated 7/3/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, end stage renal disease (kidney failure), right below the knee amputation, and peripheral vascular disease (condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident #37's Order Summary Report revealed the following:</p> <p>Insulin Regular Human Subcutaneous Solution 500 units/ml inject as per sliding scale: if 0-60 = 0 and notify MD; 61-200 = 0; 201-250 =4; 251-300 = 6; 301-350 = 8; 351-400 = 10; 401-999 = 10 and notify MD, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus (Order Date 2/21/24)</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #37's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. She used a wheelchair for mobility. She required partial to moderate assistance for most ADL's. Her insulin use was not documented on the MDS assessment.</p> <p>Review of Resident #37's Care Plan, most recent revision date 6/20/24, revealed the following:</p> <p>Focus - The resident has diabetes mellitus.</p> <p>Goals - The resident will be free from any s/sx of hyperglycemia through the review date. The resident will be free from any s/sx of hypoglycemia through the review date.</p> <p>Interventions - CBG before meals and at bedtime for DM (1/13/22). CBG two times a day for DM (2/10/22). Humulin R injection: inject as per sliding scale if 0-60 = 0units initiate hypoglycemic protocol and call MD if not resolved; 61-150 = 0units; 151 -200 = 2units; 201 - 250 = 4units; 251 - 300 = 6units; 301 - 350 = 8units; 351 - 400 = 10units; 400 or greater = notify physician - subcutaneously before meals and at bedtime for diabetes send pen needles as covered (4/4/23). Humulin R injection solution inject as per sliding scale: if 60 - 200 = 0units; 201 - 250 = 8units; 251 - 300 = 10units; 301 - 350 = 12units; 351 - 400 = 14units; 400 or greater notify physician; subcutaneously before meals and at bedtime for diabetes, send pen needles as covered (7/5/23). Novolin R injection solution 100 unit/ml inject 15units subcutaneously one time only for hyperglycemia (7/5/23). Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report PRN any s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Monitor/document/report PRN any s/sx of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.</p> <p>Resident #41</p> <p>Review of Resident #41's Admission Record revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included end stage renal disease, type 2 diabetes mellitus, and pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and heart).</p> <p>Review of Resident #41's Order Summary Report dated 7/3/24 revealed the following:</p> <p>Dialysis - Access Site Check = Check dialysis access site for thrill and bruit, redness, swelling, drainage, temperature of skin surrounding site, peripheral pulses, bleeding and intact every shift. (Order Date 5/31/24)</p> <p>Dialysis - Order For = May go to dialysis three times a week on Tuesday, Thursday, Saturday at 3:15pm. (Order Date 5/31/24)</p> <p>Dialysis - Vital Sign Checks = Check vital signs before and after dialysis, document vital signs; two times a day every Tuesday, Thursday, and Saturday. (Order Date 5/31/24)</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #41's Admission MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 12 indicating she was cognitively intact. She required a walker for mobility. She required partial to moderate assistance for some ADL's. Her use of hemodialysis was not addressed on the MDS assessment.</p> <p>Review of Resident #41's Care Plan, most recent revision date 6/3/24, revealed the following:</p> <p>Focus - Renal Dialysis</p> <p>Goals - Resident will maintain optimal function/mobility x 90 days. Resident will not incur significant problems r/t dialysis/shunt x 90 days.</p> <p>Interventions - Administer all medications per doctor's orders. Assess resident for s/s of headaches, n/v, hypertension, tremors, confusion/agitation. Check shunt before leaving for dialysis and upon returning to nursing home. Edema (swelling caused by fluid buildup in the tissue) check daily. Monitor access area for redness, pain. Monitor for chest pain, elevated blood pressure, bleeding. Monitor for itchy skin. Monitor labs per doctor's orders. Obtain vital signs before dialysis and upon return to nursing home. Send snack to dialysis with resident. Weigh resident daily before leaving for dialysis and upon returning to nursing home.</p> <p>Focus - The resident needs hemodialysis.</p> <p>Goals - The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. The resident will have no s/sx of complications from dialysis through the review date.</p> <p>Interventions - 5/31/24 Dialysis Order: May go to dialysis three times a week on Tuesday - Thursday - Saturday at 3:15pm. Check and change dressing daily at access site and document. Do not draw blood or take blood pressure in arm with graft. Encourage resident to go for the scheduled dialysis appointments. Monitor for dry skin and apply lotion as needed. Monitor intake and output. Monitor labs and report to doctor as needed.</p> <p>In an interview on 7/3/24 at 7:25pm, MDS D stated she had been working at the facility for three years as the MDS coordinator for the skilled residents. She stated that she got her information to start the MDS assessment from hospital documentation, the resident and/or their family. She stated she was responsible for completing the BIMS and depression screening questions. She stated that Resident #41 was one of the residents she was responsible for. She stated that dialysis should have been included on her MDS and the only reason it would not have been was that she overlooked it when she completed the assessment. She stated that she received corrections from her corporate supervisor each month and they would catch a mistake like that. MDS D stated that once she received corrections from her supervisor, she would do modifications to the assessments that needed them before they were submitted.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 7/3/24 at 8:01pm, MDS E stated she started her position as long-term MDS Coordinator in November of 2023. She stated she got her information to complete the assessments by interviewing the resident and their family, reviewing hospital records or physician's records. She stated there was a form she had printed as well as a form in the electronic chart to complete the assessment. She stated that some information carried over from previous assessments and some did not, so she had to pay close attention to each box to make sure everything was checked correctly. She stated that was the reason for Resident #31's insulin not being checked and Resident #33's trach not being checked on their quarterly assessments. She stated that those areas were not carried over each time and she must have just missed the boxes.</p> <p>Review of undated facility policy titled Resident Assessment revealed, in part:</p> <p>Composition of the Comprehensive Resident Assessment: The facility will make a comprehensive assessment of a resident's need, strengths, goals, life history, and preferences, using the current Resident Assessment Instrument (RAI) process, including MDS, Care Area Assessment process, and the Utilization Guidelines specified by HHSC and approved by CMS. The current RAI process is found in the MDS 3.0 and posted by CMS on http://www.cms.gov.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>45411</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 22 residents (Resident #85) reviewed for care plans.</p> <p>1. The facility failed to have a care plan in place to accurately address Resident #85's code status.</p> <p>This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.</p> <p>The findings included:</p> <p>Review of Resident #85's Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, stroke, and type 2 diabetes mellitus.</p> <p>Review of Resident #85's Quarterly MDS assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 2 indicating severe cognitive impairment. She required maximum assistance or was dependent on staff for all ADL's except for eating. She required a wheelchair for mobility.</p> <p>Review of Resident #85's Care Plan, most recent revision date [DATE] revealed the following:</p> <p>Focus - Resident and family request NO CPR/DNR measures (date initiated [DATE])</p> <p>Goal - Request for NO CPR will be respected. Will have a peaceful, pain free death. Will respect resident's wishes x 90 days.</p> <p>Interventions - [DATE] DNR Code Status. If cardiac arrest do not resuscitate. Offer reassurance and support to family. Resident code status reviewed with family and RP with each care plan review/care plan meeting.</p> <p>Focus - Resident request to be Full Code Status or Full Code due to no out of hospital form completed in place (date initiated [DATE])</p> <p>Goal - Comply with resident and family wishes for next 90 days.</p> <p>Interventions - Call for emergency personnel and initiate CPR. Resident's code status reviewed family and RP with each care plan review/care plan meeting. Respect end of life decisions.</p> <p>Review of Resident #85's Order Summary Record dated [DATE] revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DNR (Order Date [DATE])</p> <p>Review of Resident #85's Electronic Health Record on [DATE] at 4:47pm revealed scanned copy of Out of Hospital Do Not Resuscitate form signed by physician [DATE].</p> <p>In an interview on [DATE] at 8:01pm, MDS E stated she was responsible for the long-term resident care plans. She stated that Resident #85 was a DNR and she did not understand why there were care plans for both Full Code and DNR status in her care plan. She stated she would have to look into that as it did not make sense and would be confusing to anyone reading it.</p> <p>Review of undated facility policy titled Comprehensive Person-Centered Resident Care Planning revealed, in part:</p> <p>A comprehensive person-centered care plan is developed and implemented for each resident, consistent with the resident's rights and will incorporate resident-centered goals and wishes about their care, activities, and lifestyle to include measurable short-term and long-term objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed for accident hazards/supervision (Resident #23).</p> <p>The facility failed to ensure CNAs B and C demonstrated appropriate transfer techniques while using the mechanical lift for Resident #23.</p> <p>The failure could place residents at risk for injuries.</p> <p>Findings included:</p> <p>Review of Resident #23's Quarterly MDS Assessment, [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including fracture, quadriplegia (paralysis of all four limbs), Parkinsonism (neurological disease causes thinking disorders, depression and emotional changes, swallowing problems, tremors, involuntary movement, painful muscle contractions and difficulty speaking), and muscle weakness.</p> <p>She scored a 6 of 15 on her mental status exam (indicating she was severely cognitively impaired).</p> <p>She used a wheelchair.</p> <p>She was dependent on staff for all activities of daily living including chair or bed-to-chair transfers.</p> <p>Observation on [DATE] at 10:35 AM revealed Resident #23 gave permission to watch her being transferred. CNA C lowered the boom (cross piece used to hook the sling to) to the shower bed and both CNA B and CNA C hooked up to the lift Resident #23. CNA B said she was unable to get the resident hooked up right and did not understand why. CNA C explained to the Resident #23 she slid down in the shower so they had to reposition the boom a little bit. The shower bed was not locked. Once they got the hooks on the boom secured, CNA C told Resident #23 they were going up (the lift was going up to prepare the resident that she would be dangling) while CNA B made sure the boom did not hit Resident #23 in the head. Through the whole process the two aides communicated with the resident. Once in position, CNA C lowered Resident #23 in the bed while CNA B positioned the sling in the bed. CNA B and CNA C removed the wet sling and got Resident #23 dressed. CNA B and CNA C again rolled Resident #23 side to side to place the dry sling under her while pulling Resident #23's dress down as far as it would go. The CNAs hooked the dry sling onto the lift, told Resident #23 they were going up and again, CNA C operated the lift while CNA B steadied Resident #23 and engaged her in conversation CNA C moved the lift to fit under the wheelchair, locked the lift, but did not lock the wheelchair while CNA B positioned Resident #23 in the sling in the wheelchair. The aides both unhooked the sling. CNA B pulled Resident #23's dress as far as it would go, while CNA C took the lift out of the room returned and washed her hands. CNA B made sure Resident #23 was satisfied and then also washed her hands.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 10:57 AM with CNA B and CNA C CNA C asked how she did. She said she made sure the lift was locked before putting the resident down because she felt safer because Resident #23's wheelchair was specialized, and she had to approach it sideways. The Surveyor and CNA C read the lift instructions posted on the boom which reflected do not lock lift when lowering or lifting the resident. CNA C said she felt safer locking the lift when lowering the resident. CNA C said she had not asked therapy what she was supposed to do and had not received training from therapy about what she supposed to do. CNA C said she did not remember if Resident #23's wheelchair was locked and returned into Resident #23's room and checked. CNA C came back out of the room and said they did not lock the wheelchair.</p> <p>Interview on [DATE] at 09:08 AM the DON stated her expectation for a mechanical transfer was for the staff to position the sling under the resident comfortably, move the lift into position, hook the sling onto it, lift the patient up, and move the resident into the position. The DON said one staff would be maneuvering the lift while the other person was guiding the resident. The DON said the staff should put the person down, unhook and there you go. She said the staff should make sure the resident was aligned right in the chair and comfortable and unhook from the lift and take the lift away. The DON said the wheelchair needed to be locked and lift needed to be locked in place to keep the resident from falling and moving around. The DON explained if the lift of wheelchair could roll and move around, there was a possibility that it could tip and it's just not safe. The DON stated the staff were in-serviced on the mechanical lift once a year with proficiency, on hire, or if there was something that happened that was noticed. The DON said the facility did a skills brush up because their window opened in [DATE], but she would have to look. She said she knew her lead aide and staff educator had been working with the staff.</p> <p>Interview on [DATE] at 09:51 AM the Administrator stated he had not been trained on mechanical lifts but his understanding was the lift was lined up, get the resident ready sling under them, hook up the sling, lift the resident, make sure the space was clear, move the resident and put them where they need to go. The Administrator stated any general transfer from the bed to the wheelchair was the wheelchair be locked. He was informed it was not locked.</p> <p>Review of the Mechanical Lift Transfer Proficiency Checklist revealed:</p> <p>11. Move lift into position. Open the legs of the lift to their widest position, the shifter handle locked in place and do not lock the rear [NAME].</p> <p>Both CNA B and CNA C passed the proficiency check-off on [DATE].</p> <p>Review of the facility's policy and procedure on Two Person Mechanical Lift.</p> <p>Procedure.</p> <p>2. Position Wheelchair so you can maneuver the lift safely from the bed to over the chair. Lock wheels/brakes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Midland Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Mockingbird LN Midland, TX 79705	
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>Based on observation, interview and record review, the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for one of two residents (Resident #74) reviewed for enteral feedings.</p> <p>The head of the bed was not kept elevated above 30 degrees for Resident #74 to prevent aspiration pneumonia.</p> <p>This failure could place residents who are fed by enteral means at an increased risk for complications including, but not limited to, aspiration pneumonia (pneumonia caused by breathing foreign objects breathed into the lungs).</p> <p>Findings include:</p> <p>Review of Resident #74's Admission Record, dated 7/2/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included stroke and Gastrostomy Status (feeding tube).</p> <p>Review of Resident #74's Significant Change MDS Assessment, dated 6/6/24, revealed:</p> <p>Resident #74 unable to respond to questions.</p> <p>Mental status was not assessed.</p> <p>She had a feeding tube while a resident but received 25% or less of total calories and fluid intake through the parenteral or tube feeding.</p> <p>Review of Resident #74's Care Plan, initiated 10/2/23, revealed she required a PEG tube for adequate national intake. The identified goal was she would not experience adverse effects from placement of a PEG tube. Identified goals included:</p> <p>Head of bed elevated 30 - 45 degrees at all times initiated 12/19/23.</p> <p>Sign above bed, every shift date initiated 3/21/24.</p> <p>Review of Resident #74's Care Plan, initiated 5/3/24 revealed the resident required tube feeding. The identified goal included the resident would remain free of side effects or complications related to tube feeding through review date. Identified interventions included. The resident needed the head of bed elevated 45 degrees during and thirty minutes after tube feed.</p> <p>Review of Resident #74's Order Summary Report, printed 7/2/24, revealed orders dated 6/14/24: Enteral Feed Order every shift G-Tube- Head of bed elevated 30 - 45 degrees at all times.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Midland Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Mockingbird LN Midland, TX 79705	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 7/1/24 at 1:17 PM revealed Resident #74 was in her bed. There was a sign posted above her bed that reflected to keep the head of the bed above 30 degrees. Resident #74 had a feeding tube, oxygen a wound vacuum, a collar for tracheostomy care, and a catheter. The head of her bed was raised at least 45 degrees, and she was gurgling. The Surveyor activated the call light and the aides came in and stated she needed suctioning due to increase secretions visible from tracheostomy, and went to get the nurse. The aides returned, put on PPE which included a gown and gloves. The aides lowered the head of the bed to 10 degrees, and checked to see if resident #74 needed incontinent care. At this time LVN A entered the room, donned gloves and a gown. LVN A suctioned Resident #74. He stated he suctioned Resident #74 around 12:30 p.m. but it did not take long for her to get full again (need suctioning again). LVN A said if Resident #74 had drainage she needed to be suctioned. At 1:48 PM LVN A was done with Resident #74 and doffed the PPE and left to get trash bags for the room. He left Resident #74 uncovered and lying flat at 10 degrees.</p> <p>Interview and observation on 7/1/24 at 1:53 PM revealed the Surveyor called LVN A to Resident #74's bed side. The Surveyor asked LVN A what as charge nurse he should be checking for. LVN A stated that Resident #74 was not covered and covered her up; that her call light was not within reach and that her tubing was a bit of a tangle. The Surveyor then asked LVN A if Resident #74 had a peg tube and if her bed was at the right angle. LVN A stopped and said Oh, no. It's not. and raised Resident #74's bed to the right angle.</p> <p>Interview on 07/03/24 at 4:44 PM LVN A stated he did tracheostomy care on Resident #74 and left to get trash bags, so it took him a minute to get what the surveyor was asking. He agreed the head of the bed needed to be elevated. He said it was the policy because Resident #74 had a peg tube and the facility did not want her to aspirate and for the feeding formula to go to her lungs or worse. LVN A said he made that mistake because he was nervous, and he did not know Resident #74 since he was covering the hall.</p> <p>Interview on 07/03/24 at 06:48 PM the DON was informed of the 7/1/24 observation. The DON said they did not want residents with a peg tube lying flat because they could get aspiration pneumonia which was when things could get into the resident's lungs and cause infection. She said it was posted as a picture behind the bed of all residents with a peg tube for all the staff, the aides, anyone, so families would not lay residents down flat.</p> <p>Review of the facility's policy and procedure on Care of Enteral Feeding Tube, undated, revealed: Position resident in semi-Fowler's position (an individual lies on their back on a bed with the head of the bed elevated between 30 - 45 degrees).</p>		