

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Ashton Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 801 South Loop 250 West Midland, TX 79703	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</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 treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 3 of 6 residents (Residents #1, #2, and #3) observed for resident rights.</p> <p>The facility failed to ensure staff assisting Residents #1, #2, and #3 did not stand while feeding them.</p> <p>This failure could place residents at risk for decreased meal satisfaction.</p> <p>The findings included:</p> <p>Review of Resident #1's Admission Record dated 5/30/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including strokes, paralysis on one side, and brain cancer.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 5/1/24, revealed she scored a 0 of 15 on her mental status exam (indicating severe cognitive impairment). She needed substantial to maximum assistance for eating.</p> <p>Review of Resident #1's care plan, last revised on 1/12/24 revealed Focus: Resident required extensive assist with late loss ADLS and feeding assistance with meals/mechanical lift transfer. The identified goal was Resident was able to perform self-care to optimal level and maintain strength and endurance for 90 days. None of the interventions addressed eating.</p> <p>Review of Resident #2's Admission Record, dated 5/30/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including stroke, dementia, and Alzheimer's disease.</p> <p>Review of Resident #2's Significant Change MDS dated [DATE], revealed:</p> <p>She scored a 0 of 15 on her mental status exam (indicating severe cognitive impairment).</p> <p>She had physical and verbal behaviors that disrupted the resident's care and environment 1 - 3 days in the previous week. She needed substantial to maximum assistance while eating.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's Care Plan, updated 5/30/24, revealed: Focus: Resident requires extensive assistance with late loss ADLs and the use of wheelchair for locomotion. The identified goal was Resident was able to perform self-care to optimal level and maintains strength and endurance for 90 days. Interventions included encourage independence in performance in self-care and mobility within limitations.</p> <p>Review of Resident #3's Admission Record, dated 5/30/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke, dementia, and dysphagia (difficulty swallowing)</p> <p>Review of Resident #3's Significant Change MDS, dated [DATE], revealed:</p> <p>He scored a 0 of 15 on his mental status exam (indicating severe cognitive impairment).</p> <p>He needed supervision for eating.</p> <p>Review of Resident #3's care plan, dated 1/4/24 revealed a focus of Resident requires assist with ADLs. The identified goal was Resident was able to perform self-care to optimal level and maintain strength and endurance for 90 days. Interventions included encourage independence in performance of self-care and mobility within limitations.</p> <p>Review of Resident #3's care plan, updated 2/23/24 revealed, No added salt diet, regular texture, regular consistency. The goal was resident will maintain adequate nutritional status as evidenced by maintain weight through review date. Interventions included: 4/16/24 Resident no longer needs feeding assistance.</p> <p>Observation on 5/29/24 at 12:27 p.m., revealed CNA A stood while feeding Resident #1. CNA B stood while feeding Resident #2 and CNA C stood while feeding Resident #3. The lead CNA observed the three standing and brought two of them chairs, while CNA B reached behind her to another table to get a spare chair. While feeding Resident #1, CNA A had difficulty remaining seated because she kept kneeling up in the chair and then looking at the lead CNA or a nurse and sitting again.</p> <p>Interview on 5/29/24 at 12:41 p.m., the lead CNA stated CNAs needed to sit down while feeding because it was a dignity thing. The lead CNA stated the three aides forgot to get chairs and when he got them chairs, they remembered they needed to do that. The lead CNA stated the aides were monitored daily but he was responsible for monitoring the aides every Thursday. He said it had been a while since he had issues with the aides standing in the dining room while feeding.</p> <p>Observation on 5/30/24 at 12:43 p.m., staff were observed standing while feeding Resident #2.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/30/23 at 1:24 p.m., the DON stated her expectation for the meal served was that the staff be seated while feeding the residents. She said it was inappropriate for the staff to be standing because the staff were supposed to be at eye level of the resident and be able to talk to the resident about what the resident was eating to see if the resident liked something or not within the resident's therapeutic diet. The DON said there was a meal monitor in the dining room and a nurse who were responsible to monitor for that. The DON stated normally the aides' put chairs where the dependent residents were fed prior to the meal service but the dining room was currently being remodeled so it was crowded so the staff were just trying to get residents into the dining room in where they could to feed them. The DON said she did see staff sitting to feed residents. Surveyor requested a policy for feeding residents.</p> <p>Interview on 5/30/24 at 1:58 p.m., the Administrator was informed of the staff standing while feeding observations. The Administrator stated he did not feel this was an issue due to the chaos going on related to the remodel in the dining room. He stated there were not chairs available. Surveyor pointed out the lead CNA was able to bring 2 chairs immediately to the table and the third CNA was able to go to the table immediately behind her for a chair. Surveyor also pointed out chairs could have been set up at the assisted table while the dining room was half-empty rather than waiting until the dining room was full. The Administrator said sitting while feeding was not outline specifically in the facility's policy.</p> <p>Follow up interview on 5/30/24 at 3:38 p.m., the Administrator said he did some investigation and the staff only reported that they only stood while cutting up the resident's meals during set up.</p> <p>Review of in-services provided by the facility revealed the staff were in-serviced:</p> <p>4/19/24 Resident Rights on 4/19/24 that residents had the right to be treated with dignity, courtesy, consideration, and respect. (CNA A did attend this in-service)</p> <p>5/6/24: Ombudsman's Resident's rights: Resident rights include being treated with respect, dignity and consideration.</p> <p>Review of the facility's undated policy and procedure on Feeding Residents in the Dining Room revealed:</p> <p>Purpose: To be sure all residents in the dining room have the assistance needed to complete their meal.</p> <p>Procedure: Staff member should position themselves so that the resident is at eye level with the staff member for better communication with the resident and to provide feeding in a dignified manner.</p>		