STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675145	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab Odessa	3800 Englewood LN Odessa, TX 79762

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observations, interviews, and record review the facility failed to ensure that the resident's environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #19) of two residents reviewed for accidents hazards and supervision. The facility failed to ensure that Resident #19's wheelchair was properly padded to prevent injury to the resident's legs while she used it to move around the facility. This failure could lead to injury and possible infection to the resident. The findings included: Review of Resident #19's Admission Record dated 6/26/24 revealed she was an [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She had diagnoses which included dementia, major depressive disorder, anxiety disorder, malnutrition, hypothyroidism, and gastro-esophageal reflux disease. Review of Resident #19's Annual MDS assessment dated [DATE] revealed she had a BIMS score of 2 (indicating severe cognitive impairment), she had limited range of motion to one or both lower extremities requiring the use of a wheelchair, she required substantial to maximum assistance for all ADLs, and she was at risk for developing pressure ulcers. Review of Resident #19's Weekly Skin assessment dated [DATE] completed by the Treatment Nurse revealed no documented wounds. Review of Resident #19's Weekly Skin assessment dated [DATE] completed by the Treatment Nurse revealed small skin tear to back of right calf with no measurements documented. Review of Resident #19's Historical Incident Report List on 6/26/24 revealed a fall incident on 6/20/24 with no injuries noted. No other reports were documented in the past four months. Review of Resident #19's Care Plan, most recent revision date 6/26/24, revealed no care plan specifically addressing her risk for injury due to her wheelchair. The care plan did address her risk for skin breakdown/pressure ulcer development and her need for assistance with ADL performance. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/26/24 at 9:40 am revealed Resident #19 resting in bed. When this state surveyor spoke to her, she began pulling at the blankets covering her legs. This state surveyor assisted her in revealing her legs and noted an open area on her left calf with 2 steri-strips covering it that were saturated in old, bloody drainage, and a second scabbed over area just below dressed wound with no dressing in place. Resident #19 attempted to communicate in Spanish, so this state surveyor asked the DON to come to the room to translate. Resident #19 was confused in her explanation of how she got the wounds on her left leg. The DON stated that she believed the wounds on Resident 19's legs were from a transfer to her wheelchair which was kept wrapped with sheepskin to prevent further wounds from occurring. The DON stated that the resident had been sent to the ER the previous night for elevated blood pressure, but she (the DON) had not been made aware of any new skin issues and she had not seen the calf wounds before. In an interview on 6/27/24 at 11:40 am the Treatment Nurse stated the wounds on Resident #19's left calf were not present when she completed her weekly skin assessment on 6/17/24. She stated was off work from 6/20/24 until 6/23/24, and she was not sure how the wounds on Resident #19's left leg happened or who dressed them. The Treatment Nurse stated she believed that they happened during a transfer to or from her wheelchair. She stated the staff have wrapped the area of the wheelchair where the footrests hook on in sheepskin to prevent these injuries. She stated that the skin assessment from 6/24/24 said right calf, but due to the way the resident laid in bed with her legs tucked up she (Treatment Nurse) could have mistakenly documented the wrong site. She stated that the shower aides documented skin issues on shower sheets. She stated that the shower sheets [NAME] kept in a book in her office, and she reviewed them resident by resident when she returned from being off (on weekends), and it could take her a while to catch up with all the skin issues identified by the shower aides if she was not told about them directly. In an interview on 6/27/24 at 6:27 pm, when informed that there was no investigation into the cause of the wounds or when they had occurred, the DON stated that she started an investigation. This state surveyor stated that the DON was not aware of the wounds until this state surveyor showed them to her (the DON) on 6/26/24 and that was when she started her investigation. The DON stated that was true. The DON stated that the treatment nurse followed up on newly reported wounds by using the shower sheets that the shower aides documented on. The Administrator and the DON were informed that the wounds had not been documented on Resident #19's shower sheets, nurse's notes, and no incident/accident report had been completed in the past week. The Administrator stated that both the treatment nurse and the shower aide for Resident #19's hall were out of the facility at the end of last week which she (Administrator) felt accounted for the lack of documentation of the wounds. The Administrator and the DON were informed that when this surveyor discovered the wounds, there was a dressing in place on one of the wounds. The DON stated that Resident #19 had not left the facility in the past week and she could not explain where the dressing came from. The DON stated the most likely cause of the wound was the resident's wheelchair, but no one had been able to tell her exactly what happened or when. The DON stated that while she had started an incident/accident report, her investigation was ongoing. The DON stated that the staff had wrapped the section of the resident's wheelchair that the footrests hook on with sheepskin to pad the area and protect the resident's legs, but it slips down, and she planned to work with the therapy department on a better option for protecting the resident's legs. Review of facility policy titled Skin Assessment revision date 8/15/16 revealed, in part: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. All new admits and residents returning from a hospital stay will have a head-to-toe skin assessment completed by the Treatment Nurse/designee within four (4) hours of the resident's arrival at the facility. a. If the Treatment Nurse/designee is not available, then the charge nurse should complete the skin assessment within four (4) hours of the resident's arrival at the facility. i. The charge nurse will then notify the Treatment Nurse/designee of any skin concerns and complete the appropriate attachments/assessments. ii. The DON or designee, along with the Treatment Nurse/designee and other team members will review for the follow-up assessment and recommendations. Any pressure ulcer should also be care planned. Any alterations in skin integrity will be treated according to physician orders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record review, the facility failed to provide pharmaceutical services to ensure accurate administration and documentation of medications for 3 of 12 residents (Residents #24, #69, and #43) reviewed for pharmacy services and medication administration. The facility failed to administer blood pressure medications as prescribed for Residents #24 and #69. The facility failed to ensure Resident #43 had parameters outlining when to hold her short-acting insulin. This failure placed residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. The findings included: Review of Resident #24's Admission Record, dated 6/27/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke and hypertension (high blood pressure). Review of Resident #24's Annual MDS assessment dated [DATE], revealed: He scored a 9 of 15 on his mental status exam (indicating moderate cognitive impairment) and showed signs of delirium including inattention and disorganized thinking. Active diagnoses included hypertension. Review of Resident #24's Care Plan, revised on 2/22/24, documented Resident #24 had a diagnosis of hypertension. The goal was Resident #24 would remain free from signs and symptoms of hypertension through the review date. Identified interventions included: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (blood pressure dropping when standing) and increased heart rate (tachycardia) and effectiveness. Obtain blood pressure readings at least weekly unless ordered by the physician to be obtained more frequently. Review of Resident #24's Order Summary Report, dated 6/27/24, revealed orders: Metoprolol Tartrate Tablet 50 mg, give 1 tablet by mouth two times a day related to hypertension hold if systolic (blood pressure is) less than 100 or heart rate is less than 60. Start date 5/25/24. Review of Resident #24's June 2024 MAR (6/1/24 through the morning of 6/27/24), revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Metoprolol Tartrate Tablet 50mg, give 1 tablet by mouth two times a day related to Essential Hypertension hold if systolic (blood pressure is) less than 100 or heart rate is less than 60. 6/13/24 evening dose (time not specified) Blood Pressure 98/61. The medication was initialed as given by MA F. In an interview on 6/27/24 at 11:53 AM the DON stated Resident #24 had a different doctor and different parameters than other residents and she could see how it could confuse nurses and leave the facility open to errors. The DON said Resident #24's parameters were systolic blood pressure less than 100 or heart rate less than 60. The DON stated on 6/13/24, Resident #24's Blood Pressure was 98/61. The DON confirmed Resident #24 received the medication and he should not have. Review of Resident #69's Admission Record dated 6/27/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hypertension. Review of Resident #69's Quarterly MDS Assessment, dated 3/25/24, revealed: She scored a 12 of 15 on her mental status exam (indicating she was moderately cognitively impaired). Active diagnoses included hypertension. Review of Resident #69's Care Plan, revised 3/28/24, revealed: Resident #69 has hypertension related to [blank]. The goal was Resident #69 would remain free of complication related to hypertension through review date. Identified interventions included: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (blood pressure dropping when standing) and increased heart rate (tachycardia) and effectiveness. Obtain blood pressure readings at least weekly unless ordered by the physician to be obtained more frequently. Review of Resident #69's Order Summary Report, reviewed 6/27/24, revealed orders for Metoprolol Tartrate Tablet 50mg, give 1 tablet by mouth two times daily for hypertension hold if systolic blood pressure is less than 110 or pulse less than 60. Start date 5/6/24. Review of Resident #69's June 2024 MAR (6/1/24 through the morning of 6/27/24) revealed: 6/10/24 evening blood pressure 106/67. The medication was initialed as given by MA G. 6/17/24 evening blood pressure 105/60. The medication was initialed as given by MA G. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/27/24 at 11:24 p.m. the DON stated Resident #69's blood pressure parameters were to hold her Metoprolol if her systolic blood pressure was less than 110 or pulse less than 60. The DON said on the evening on 6/10/24 Resident #69's blood pressure was 106/67. The DON said the blood pressure medication was given and it should not have been. The DON said on the evening of 6/17/24 Resident #69's blood pressure was 105/60. The DON stated the medication was given and it should not have been. Review of the facility's policy and procedure on Medication Administrator Procedures, revised 10/25/17, revealed: When ordered or indicated, included specific item(s) to monitor (e.g. blood pressure, pulse, blood sugar, weight), frequency (e.g., weekly, daily), timing (e.g. before or after administering the medication), and parameters for notifying the prescriber. Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of nurses and/or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence. Review of Resident #43's Admission Record dated 6/27/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (condition that affects how the body uses sugar as a fuel). Review of Resident #43's Annual MDS Assessment, dated 5/30/24, revealed: She scored a 12 of 15 on her mental status exam indicating she was cognitively intact. She needed substantial/maximum assistance with all ADLs except eating. Active diagnoses included diabetes. She received insulin injections 7 of 7 days prior to the assessment. Review of Resident #43's care plan, revised 3/26/24, revealed: Resident #43 had Diabetes Mellitus. The goal was Resident #43 would have no complications related to diabetes through the review date. Identified interventions included: Diabetes medications as ordered by the doctor. Monitor/Document for side effects and effectiveness. Fasting Serum Blood Sugar as ordered by doctor . (blood sugar taken before food was ingested). Review of Resident #43's Order Summary Report, dated 6/27/24, revealed orders: Insulin Gargine Solution (long- acting insulin) 45 units subcutaneously two times a day for diabetes beginning 5/25/24. Novolog Solution (short acting insulin) 12 units subcutaneously before meals for diabetes beginning 6/19/23. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's Treatment Administration Record for 6/1/24 - 6/27/24 revealed she received Novolog 12 units with her blood sugar below 90 on the following dates: 6/2/24 at 11:30 a.m. blood sugar of 74 by the DON (next blood sugar at 4:30 p.m. was 107) 6/20/24 at 7:30 a.m. blood sugar of 87 by LVN E (11:30 a.m. blood sugar was 113) In an interview on 06/27/24 at 12:20 PM the DON stated Novolog was short acting insulin. She stated the standing parameters on when to hold insulin was to hold when a resident's blood sugar was under 60 and notify the doctor. The DON stated the facility held insulin when the doctor's order specified or when it was discussed with the doctor. The DON said there were no parameters on when to hold Novolog. The DON stated if a resident's blood sugar was 87 and they were given short-acting insulin it would depend on what the resident ate. She stated if the resident was given food within the normal range there should not be any reaction. The DON said she would be comfortable giving insulin to a resident with a blood sugar of 74. The DON said the residents should not be waiting more than 30 minutes between when given insulin and food. The DON stated the nurses knew the residents and they knew who to bring snacks to. The DON said the outcome to the resident to getting insulin if they did not get food within that 30-minute window was their insulin level would drop. The Regional Consultant, who was present, stated the facility always had to notify the physician if they held insulin, but they could wait for the food to arrive, check the blood glucose level, and administer the insulin then. In an interview on 6/27/24 at 5:50 pm when LVN B was asked if she would give a resident with a blood sugar of 74 their scheduled dose of 12 units of fast acting insulin without consulting the physician, she said it would depend on the resident and what they had eaten that day, what their appetite was like, what other diabetic medications they were taking; but generally speaking, no she would not ever feel safe giving that much insulin to a resident with that low of a blood sugar, especially first thing in the morning. She stated that she would hold the dose and call the physician for clarification of the order. She stated that to her knowledge that facility did not have any standing parameters regarding insulin administration and that most of the orders she had seen from the physicians did not have parameters as to when to hold doses and notify the ordering physician. In a follow up interview on 06/27/24 at 06:02 PM the Regional Consultant stated he reviewed Resident #43's record and stated there was no way to say if it was her mental status or her blood sugar that crashed. He said there was no hold parameter on the Novolog. The Regional Consultant stated insulin was given right before meals. He said blood sugars were checked 30 - 60 minutes before breakfast. The Regional Consultant said the resident did not say her blood sugar crashed, he did not have a nurses note saying she crashed, he did not have a doctor saying she crashed, and he did not have a hospital saying her blood sugar crashed. He said he called Resident #43's doctor and got a hold parameter for the Novolog for 90 and to notify the physician if the blood sugar was less than 60. In an interview on 06/27/24 at 06:31 PM, the Administrator was informed of the lack of parameters on holding fast acting insulin for diabetic residents. The Administrator concern was that an outcome for the resident was missed. Review of the facility's policy and procedure on Nursing Care of the Resident with Diabetes Mellitus, dated 5/7/13, revealed Diabetes is a disorder in which there is relative or absolute lack of insulin. Among other things, glucose (sugar) from food cannot be taken up by the cells. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conditions Associated with Diabetes. The following conditions are associated with diabetes: 3. Hypoglycemia (blood sugar below reference ranges). Signs and symptoms of hypoglycemia usually have a sudden onset and may include the following: a. weakness, dizziness, or faintness; b. restlessness and/or muscle twitching; c. tachycardia (increased heart hate); d. pale, cool moist skin; e. excessive perspiration; f. irritability or bizarre changes in behavior; g. blurred or impaired vision; h. headaches; i. numbness of the tongue and lips/ thick speech; j. (more severe) stupor, unconsciousness and/or convulsions; and k. (more severe) coma. If these, or other abnormal conditions exist, notify the physician. 5. Approximate reference range for hypoglycemia are: a. Mild hypoglycemia 55 - 70 mg/dl. Review of the facility's policy and procedure on Notifying the Physician of Change in Status, revised 3/11/13, revealed: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. 11. Abnormal lab, x-ray and other diagnostic reports require physician notification. Record review from; NovoLog Flexpen off the internet 6/27/24: Usage, Side Effects, Warnings (drugs.com) NovoLog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. NovoLog is used to improve blood sugar control in adults and children with diabetes mellitus. Low blood sugar (hypoglycemia) can happen to anyone who has diabetes. Symptoms include headache, hunger, sweating, irritability, dizziness, nausea, and feeling anxious or shaky. To quickly treat low blood sugar, always keep a fast-acting source of sugar with you such as fruit juice, hard candy, crackers, raisins, or non-diet soda.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #79) of 3 residents reviewed for infection control. CNA A failed to wash his hands and change his gloves after they became contaminated during incontinent care while assisting Resident #79. This failure could place residents at risk for cross contamination and the spread of infection. Finding included: Record review of Resident #79's admission record dated 06/25/24 indicated she was admitted to the facility on [DATE] with diagnoses of muscle weakness and reduced mobility. She was [AGE] years of age. Record review of Resident #79's care plan dated 05/24/24 indicated in part: Focus: The resident has bladder incontinence. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: INCONTINENT care at least every 2 hours and apply moisture barrier after each episode. Record review of Resident #79's MDS dated [DATE] indicated in part: BIMS = 11 indicating resident was moderately impaired. Urinary continence = Always incontinent. Bowel continence = Frequently incontinent. During an interview and observation on 06/25/24 at 09:04 AM, CNA A performed incontinent care for Resident # 79. CNA A entered the resident's room, washed his hands, and put some gloves on. The CNA A then undid the resident's brief, took some wet wipes, and wiped the residents' vaginal area. The resident's brief was noted to be soaked with urine. The resident said that whenever she drank some soda, she would urinate a lot. CNA A then turned the resident on her side, while wearing the same gloves he used to wipe the vaginal area, he took the new brief and placed it on the bed by the resident. CNA A noticed the bed sheets were wet with urine, so he undid the sheets, removed his gloves, and left the room to get some clean sheets. CNA A re-entered the room and put on a pair of clean gloves and did not sanitize or wash his hands first. CNA A then proceeded with the incontinent care as he had not yet performed peri-care to the resident's bottom and rectal area. CNA A next applied some skin protection ointment to the resident's buttocks and while still wearing the same gloves, he assisted Resident #79 with getting dressed then fastened a gait belt around the resident and assisted her up into her wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 11:46 AM, CNA A said he should have washed or sanitized his hands and changed his gloves before he touched the clean brief. CNA A said he also should have washed or sanitized his hands when he returned back to the room with the clean linen. CNA A said he should have changed his gloves before he fastened the new brief on Resident #79 and helped dress her and transfer her to the wheelchair. CNA A said if he did not wash or sanitize his hands it could lead to cross contamination and spread of infections. During an interview on 06/27/24 at 03:55 PM, the DON said it was expected for the staff to change their gloves once they became contaminated. The DON said the CNA should have washed his hands prior to putting clean gloves on after he returned to the resident's room with the clean linen. The DON said the CNA should have changed his gloves before he assisted Resident #79 with the new brief, dressing, and assisted her out of bed. The DON said the CNA perhaps got nervous and forgot his steps during incontinent care. The DON said the CNA not changing his gloves or washing his hands could lead to cross contamination. The DON said they conducted proficiency checks upon hire and annually. During an interview on 06/27/24 at 04:42 PM the Administrator said it was expected for CNAs to change their gloves once they became contaminated to prevent cross contamination. The Administrator believed the failure occurred because the CNA got nervous and forgot his steps. The Administrator said they conducted proficiency checks to monitor and train staff. Record review of the facility's policy titled Perineal care dated 05/11/2022 indicated in part: It is essential that residents using various devices, absorbent products, external collection devices etc, be checked (and changed as needed) on a scheduled based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations. Purpose: This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infection and skin irritation, and observing the resident's skin condition. Perform hand hygiene, DON gloves and all other PPE per standard precautions. Gently perform perineal care, wiping from clean, urethral area to dirty rectal area to avoid contaminating the urethral area - clean to dirty. Female resident: Working from front to back, wipe one side of the labia majora, the outside folds or perineal skin that protect the urinary meatus and the vaginal opening. Gently perform care to the buttocks and anal area working from front to back without contaminating the perineal area. Record review of the facility's policy titled Infection control policy & procedure manual 2019 dated 03/2024 indicated in part: Wearing gloves does not replace the need for handwashing because gloves may have small inapparent defects or be torn during use and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard. Recommended techniques for performing hand hygiene with an ABHR - include applying product to the palm of one hand and rubbing hands together covering all surfaces of hands and fingers until the hands are dry. In addition, gloves or the use of baby wipes are not a substitute for hand hygiene. Record review of the facility's undated policy titled Hand Hygiene indicated in part: You may use alcohol-based hand cleaner or soap/water for the following: Before and after assisting a resident with personal care, upon and after coming in contact with a resident's intact skin. After removing gloves or aprons. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Infection control plan: overview dated 03/2024 indicated in part: The facility will establish and maintain an infection control program designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls, and prevents infections in the facility. Decides what procedures such as isolation should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections.