

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Mountain View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Murchison Rd El Paso, TX 79902	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview and record review the facility failed to ensure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 5 residents (Resident #16) reviewed for freedom from physical restraints.</p> <p>-The facility failed to obtain consent, physician's order, and care plan for Resident #16's full bed rails in which the resident movements were restricted and there was no documentation the restraints were required to treat her medical symptoms.</p> <p>This failure could put residents at risk of unnecessary restriction of their freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control).</p> <p>Findings included:</p> <p>Record review of Resident #16's admission record dated 05/06/2024, revealed a [AGE] year-old female admitted to the facility 03/22/2024.</p> <p>Record review of Resident #16's H&P dated 03/28/2024, revealed a [AGE] year-old female with a past medical history of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), CVA (an interruption in the flow of blood to cells in the brain) with right-sided deficits, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movement, behaviors, sensations or states of awareness).</p> <p>Record review of Resident #16's initial MDS, dated [DATE], revealed a BIMS score of 01 indicating the resident had severe cognitive impairment. Further review revealed Section GG - Functional Abilities and Goals revealed Resident #16 had impairment to one side of upper and lower body. She was dependent with bed mobility and transfers. Section P - Restraints and Alarms revealed that bed rails were not used in bed.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #16's Care Plan initiated 03/22/2024, reflected no information regarding the use of full bed rails.</p> <p>Record review of Resident #16's Order Summary dated 05/06/2024, reflected no information related to the use of bed rails.</p> <p>Observation and interview on 05/06/2024 at 2:29 p.m., revealed Resident #16 lying on a bed with raised full side bed rails. Resident #16 was greeted and asked questions to which Resident#16 did not offer any response.</p> <p>During an interview on 05/06/2024 at 2:32 p.m., RN C said Resident #16 was a Hospice patient. RN C said resident was not oriented and unable to respond to questions by any means. RN C said Resident #16 required total assistance with bed mobility and transfers. RN C said the bed was brought to the facility by Hospice. RN C said she did not think there was a need for an order for bedrails since the bed came from Hospice. RN C said she did not know why Resident #16 needed full side bed rails as she does not get up and was bedbound. RN C said since the facility allowed the bed to be at the facility, she thought the bed with rails was allowed. RN C said Resident #16 had been at the facility for a little over a month and she had used the bed with full side rails up throughout that time.</p> <p>During an interview on 05/06/2024 at 3:25 p.m., the DON said she was not aware that Resident #16 had full side bed rails. The DON said the facility does not use bed rails as this may be a restraint. The DON said she needed to find out more information regarding the bed rails.</p> <p>During an interview on 05/06/2024 at 4:07 p.m., the Administrator said that the bed rails on Resident #16's bed were removed. The Administrator said Resident #16 was receiving Hospice services and the bed appeared to have been provided by Hospice. The Administrator said she was reaching out to Hospice to gather more information. The Administrator said full bed rails were not used at the facility as they may be considered a restraint.</p> <p>During an interview on 05/07/2024 at 10:43 a.m., the Administrator said the DON shared with her that full side bed rails were in place for Resident #16. The Administrator said the facility does not use full side bed rails. The Administrator said she called Hospice, and they said it was an error by their DME company. The Administrator said upon learning of the bed rails on 05/06/2024, they immediately removed the side rails. The Administrator said the DME company delivered Resident #16 the bed on 04/01/2024. The Administrator said they did not have orders for the bed rails. The Administrator said no one had brought this issue to her attention prior to 05/06/2024. The Administrator said facility staff had been in-serviced on restraints after receiving a citation on restraints on a recent survey visit.</p> <p>Record review of Resident #16's incidents since admission on 03/22/2024, revealed no falls or any other incident/injuries.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/09/2024 at 11:30 a.m., the DON said full side rails were not allowed at the facility. The DON said that would be considered a restraint. The DON said all staff were trained to identify and report any issues with restraints. The DON said specifically staff were to tell the nurse if they find any concerns. The DON said they were a restraint free facility. The DON said Resident #16 does not get up on her own and requires total assistance. The DON said risk of using bed rails was resident would be restrained from movement, attempt to climb over the rails or become entangled in the rails. The DON said Resident #16 does not move without staff assistance which minimizes the risk for her but still she should not have had the full side bed rails. The DON said the bed was in place for about three weeks to almost a month.</p> <p>Record review of the facility policy Restraints dated 02/01/2007, reads in part, It is the policy of this facility to maintain an environment that prohibits the use of restraints for discipline or convenience. Restraints will only be applied after it has been determined that a medical symptom requiring restraint usage exist, and only after other alternatives have been tried unsuccessfully. A physician's order shall be necessary to begin a restraint assessment/evaluation for the resident. Facility staff will develop a care plan for the alternate method identified and/or the restraint usage. Restraints will only be used with informed consent from the resident and/or the resident's representative or responsible party and the residents' physician. Practices that are not to be used: Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who are incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 (Resident #16, and Resident #17) of 5 residents reviewed for quality of care.</p> <ol style="list-style-type: none"> The facility failed to ensure Residents #16's and #17's catheter leg strap was in place to secure the catheter. The facility failed to ensure Resident #17's drainage bag was off the floor. <p>This failure could place residents with foley catheters at risk of catheter pulling causing pain and/or infection and risk for infection due to improper care practices and cross contamination.</p> <p>Findings include:</p> <p>Resident #16:</p> <p>Record review of Resident #16's admission record dated 05/06/2024, revealed a [AGE] year-old female admitted to the facility 03/22/2024.</p> <p>Record review of Resident #16's H&P dated 03/28/2024, revealed a [AGE] year-old female with a past medical history of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), CVA (an interruption in the flow of blood to cells in the brain) with right-sided deficits, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and seizures (burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movement, behaviors, sensations or states of awareness).</p> <p>Record review of Resident #16's initial MDS, dated [DATE], revealed a BIMS score of 01 indicating the resident had severe cognitive impairment. Further review revealed Section H - Bladder and Bowel revealed Resident #16 had an indwelling catheter.</p> <p>Record review of Resident #16's Care Plan initiated on 03/22/2024, reflected Resident #16 had an Indwelling Catheter. Intervention step includes: Ensure tubing is anchored to the resident's leg or linens so that tubing is not pulling on the urethra.</p> <p>Record review of Resident #16's Order Summary dated 05/06/2024, reflected orders to Urinary Catheter to gravity drainage every shift for neurogenic bladder. Ensure catheter strap in place and holding every shift change as needed.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview on 05/06/2024 at 2:32 p.m., visited Resident #16 with RN C revealed resident did not have a catheter strap on to her leg or linen. RN C said she did not know how long Resident #16 did not have a catheter strap on. RN C said the risk of not having the catheter strap in place was the catheter being pulled out that may cause pain and discomfort.</p> <p>Resident #17:</p> <p>Record review of Resident #17's admission record dated 05/06/2024, revealed a [AGE] year-old male admitted to the facility 04/23/2021.</p> <p>Record review of Resident #17's H&P dated 06/06/2023, revealed diagnoses that included acute kidney injury, unknown baseline.</p> <p>Record review of Resident #17's quarterly MDS, dated [DATE], revealed a BIMS score of 00 indicating the resident had severe cognitive impairment. Further review revealed Section H - Bladder and Bowel revealed Resident #17 had an indwelling catheter.</p> <p>Record review of Resident #17's Care Plan initiated on 04/23/2021, reflected Resident #17 had a indwelling catheter: neuromuscular dysfunction of bladder. Intervention steps included: Check tubing for kinks and maintain the drainage bag off the floor.</p> <p>Record review of Resident #17's Order Summary dated 05/06/2024, reflected orders to Ensure catheter strap in place and holding every shift change as needed.</p> <p>Observation on 05/06/2024 at 11:27 a.m., revealed Resident #17 lying in bed with catheter drainage bag lying on the floor.</p> <p>During observation and interview on 05/06/2024 at 2:38 p.m., visited Resident #17 with RN C which revealed resident did not have a catheter strap in place. RN C said she did not know how long Resident #17 was without the catheter strap. RN C said the risk of not having the catheter strap in place was the catheter being pulled out that may cause pain and discomfort. RN C said Resident #17 had not had any issues with UTIs.</p> <p>Observation on 05/08/2024 at 9:35 a.m., revealed Resident #17 lying in bed with catheter drainage bag lying flat on a bed side floor mat.</p> <p>Interview on 5/9/24 at 11:30 a.m., the DON stated indwelling catheter there were orders that secure disk is there and peri-care is done. The DON stated if CNA sees disk is not the notified a nurse to replace. The DON stated foley care done during annual competencies and as needed. The DON stated Relias also generated. The DON stated Facility nursing and CNAs would have completed recently I think within the last three months. The DON stated If on the bed the foley is lower than the patient to drain adequately. The DON stated the drainage bag should not be on the ground. The DON stated the risk of contamination of foley and infection. The DON stated the risk of not having disk not in place is tugging and trauma .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Catheter Care dated 02/13/2007, reads in part, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. Review the resident's plan of care daily for changes. Be sure the catheter tubing and drainage bag are kept off the floor.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on observation, interview, and record review 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 diseases and infections for 1 of 7 (Resident #7) residents reviewed for Covid-19.</p> <p>The facility failed to ensure Resident #7's, who was isolated for Covid-19, door was kept closed.</p> <p>This failure could put residents at risk of exposure to Covid-19.</p> <p>The findings included:</p> <p>Record review of Resident #7's face sheet dated 5/7/24 revealed a [AGE] year-old female with diagnoses of COPD, asthma, and schizoaffective disorder.</p> <p>Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMS score of 4, indicating her cognitive was severely impaired.</p> <p>Record review of Resident #7's progress note dated 5/1/24 read in part [Resident #7] tested positive for Covid-19. Room change for Covid-19 precautions.</p> <p>Observation on 5/6/24 at 10:11 am, revealed Resident #7's door was wide open, red tape by the door, and sign that stated doors to be closed.</p> <p>Interview on 5/6/24 at 10:16 am, CNA D stated she had received training on Covid-19 precautions that included in part to keep Covid-19 isolated rooms doors always closed. CNA D stated all staff were responsible of ensuring Covid-19 isolated rooms were kept closed. CNA D stated the facility was able to identify positive Covid-19 isolated rooms by the red tape that was placed by their entrance door, PPE bin available by entrance and the signs to warn it was a hot zone. CNA D stated by failing to maintain positive Covid-19 isolated rooms doors closed, there was risk of cross contamination and risk of quired infection.</p> <p>Observation on 5/7/24 at 9:31 am, revealed Resident #7's door was wide open, red tape by the door, and sign that stated doors to be closed.</p> <p>Observation on 5/7/24 at 10:03 am, revealed Resident #7's door was wide open, red tape by the door, and sign that stated doors to be closed.</p> <p>Interview on 5/7/24 at 2:18 pm, CNA E stated she had received training on Covid-19 precautions that included in part to keep Covid-19 isolated rooms doors always closed. CNA E stated all staff were responsible of ensuring Covid-19 isolated rooms were kept closed. CNA E stated the facility was able to identify positive Covid-19 isolated rooms by the red tape that was placed by their entrance door, PPE bin available by entrance and the signs to warn it was a hot zone. CNA E stated by failing to maintain positive Covid-19 isolated rooms doors closed, there was risk of cross contamination and risk of quired infection.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/7/24 at 2:32 pm, CNA F stated she had received training on Covid-19 precautions that included in part to keep Covid-19 isolated rooms doors always closed. CNA F stated all staff were responsible of ensuring Covid-19 isolated rooms were kept closed. CNA F stated the facility was able to identify positive Covid-19 isolated rooms by the red tape that was placed by their entrance door, PPE bin available by entrance and the signs to warn it was a hot zone. CNA F stated by failing to maintain positive Covid-19 isolated rooms doors closed, there was risk of cross contamination and risk of quired infection.</p> <p>Interview on 5/7/24 at 2:40 pm, Med Tech G stated she had received training on Covid-19 precautions that included in part to keep Covid-19 isolated rooms doors always closed. Med Tech G stated all staff were responsible of ensuring Covid-19 isolated rooms were kept closed. Med Tech G stated the facility was able to identify positive Covid-19 isolated rooms by the red tape that was placed by their entrance door, PPE bin available by entrance and the signs to warn it was a hot zone. Med Tech G stated by failing to maintain positive Covid-19 isolated rooms doors closed, there was risk of cross contamination and risk of quired infection.</p> <p>Interview on 5/9/24 at 11:39 am, the DON stated the facility staff had received training on Covid-19 precautions that included in part to keep Covid-19 isolated rooms doors always closed. The DON stated all staff were responsible of ensuring Covid-19 isolated rooms were kept closed. The DON stated the facility was able to identify positive Covid-19 isolated rooms by the red tape that was placed by their entrance door, PPE bin available by entrance and the signs to warn it was a hot zone. The DON stated by failing to maintain positive Covid-19 isolated rooms doors closed, there was risk of cross contamination and risk of quired infection.</p> <p>Record review of Interim Infection Prevention and Control Recommendation for Healthcare personnel During the Coronavirus Diseases 2019 pandemic policy dated 5/8/23 read in part .Patient Placement: place patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. the door should be kept closed.</p>