

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER El Paso Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11525 Vista Del Sol Dr El Paso, TX 79936	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</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 provide a safe, clean, comfortable, and homelike environment for 1 (Resident #10) of 6 residents reviewed for resident rights.</p> <p>-The facility failed to ensure Resident #10's bedroom was clean and comfortable based on a dead roach being inside the resident's bed light fixture.</p> <p>This failure could place the resident at risk of decreased quality of life due to the lack of a well-maintained environment.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 04/16/2024, revealed a [AGE] year-old male who was originally admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #10's H&P dated 06/25/2023, revealed Resident #10's diagnoses to include hypertension, gait abnormality/difficulty walking and depression.</p> <p>Record review of Resident #10's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 indicating the person is intact cognitively.</p> <p>During an observation and interview on 04/09/2024 at 3:30 p.m., Resident #10 said he felt that the facility staff does not clean thoroughly. Resident #10 pointed out a light fixture located above his bed and said that there is a dead roach inside the fixture that had been there since he moved into the room in January 2024. Resident #10 said he had mentioned it to staff in the past, but the issue had not been resolved. Resident #10 said that it bothered him to see that a dead roach remains in the light fixture casing. Resident #10 said he does not see as many pests recently but in the past had seen roaches and pests come in through the restroom wall with a metal plate that has small open areas around the plate.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2024 at 04/09/2024 at 4:00 p.m., the HKS said resident hallways are cleaned every day. The HKS said there were only two housekeepers working each day to clean up two hallways each. The HKS said housekeeping sweep and mop floors, pick up trash, clean furniture to include dressers and nightstands. The HKS said housekeeping staff should be dusting the light fixtures in the room. The HKS said she was not aware that there was a dead roach in Resident #10's bedroom light fixture. The HKS said housekeeping is responsible for cleaning out the fixture and will follow up with hallway housekeeper to make sure she cleans out the fixture. The HKS said housekeeping should be checking the environment to make sure all areas are clean.</p> <p>Review of facility policy titled Deep Cleaning Process - Resident Room dated 2015, reads in part, High dusting and lights: clean lights in the ceiling and above the bed using microfiber high dusting tool. Be sure to remove any bugs inside lights.</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** 46998</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs and the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for care plans in that:</p> <p>The facility failed to implement a comprehensive person-centered care plan for Resident #1 requiring wearing cushion boots (redistributing device for the prevention of heel pressure ulcers).</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 04/11/24, revealed, admission on 04/12/23 to the facility.</p> <p>Record review of Resident #1's significant change in status MDS assessment dated [DATE], revealed, he was cognitively intact to be able to make daily decisions and able to recall information with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 14. Resident #1 was diagnosed with Diabetes Mellitus, Pressure Ulcer of Sacral Stage 4, Pressure Ulcer of Unspecified site stage 4. Muscle wasting and atrophy (a joint disease, of which arthritis is a type). At risk for pressure ulcers. Resident #1 was marked down for having one or more unhealed pressure ulcers. Marked for pressure ulcer care. Care Area Assessment revealed care area trigger and care planning.</p> <p>Record review of Resident #1's care plan dated 04/10/24, revealed, has a pressure ulcer or potential for pressure ulcer development. Deep tissue injury to left and right heel. Administer medications as ordered. Administer treatment as ordered and monitor for effectiveness. Left heel: clean with normal saline, pat dry, apply collagen sheet and cover with bordered gauze dressing. Ensure heels are floated with the use of pillows. There was no mention of Resident #1 having to wear cushion boots.</p> <p>Record review of Resident #1's order recap dated 04/10/24, revealed, there were no orders from physician indicating that Resident #1 had to use cushion boots. Order dated 03/18/24, revealed, deep tissue injury to left heel: clean with normal saline, pat dry, apply collagen sheet, cover with gauze dressing, as needed and every day shift every Mon, Wed, Fri for wound care. Order dated 03/14/24, revealed, deep tissue injury to right heel: clean with normal saline, pat dry, apply betadine, cover with bordered gauze dressing, as needed and every day shift for wound care.</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>Observation on 04/10/24 at 11:54 AM, with the Wound Care Nurse. The Wound Care Nurse was looking for the cushion boots and found them on the dresser. Resident #1 had pillows underneath his knees. The Wound Care Nurse told Resident #1 that he needed to have the cushion boots on as well to help heal his heels that had the pressure ulcers. Resident #1 stated he keeps telling the CNAs over and over and over again, but they do not put on the cushion boots.</p> <p>During an interview on 04/10/24 at 12:18 PM, with the Wound Care Nurse, she stated Resident #1 needed to have his cushion boots on to help heal his heels from the pressure ulcers. The Wound Care Nurse stated when wound care started, Resident #1 did not have his cushion boots on. The Wound Care Nurse stated she had already educated the nursing staff and Resident #1 in regard to having the cushion boots on to promote healing. The Wound Care Nurse stated not having the cushion boots could slow down the healing process or the wound could get worse. The Wound Care Nurse stated the cushion boots should be in the care plan of Resident #1. The Wound Care Nurse stated care planning would have let the nurses know to have the cushion boots on and not care planning it could lead to the wound worsening.</p> <p>During an interview on 04/11/24 at 8:59 AM, with CNA H, she stated when showering or moving residents that have pressure ulcers on their heels, the nursing staff if ordered has to put on the cushion boots once they are done moving or showering the resident. CNA H stated not putting on the cushion boots could result in the injury getting injured more.</p> <p>During an interview on 04/11/24 at 1:17 PM, with CNA E, she stated if a resident was required to have cushion boots on then once the nursing staff has completed doing whatever they were doing with the resident, then they have to put back on the cushion boots. CNA E stated this was so no more pressure ulcers developed.</p> <p>During an interview on 04/11/24 at 4:09 PM, with LVN D, she stated cushion boots should be care planned for a resident. LVN D stated a care plan was to provide the services a resident would need. LVN D stated not care planning the cushion boots for a resident with pressure ulcers could result in wounds getting worse.</p> <p>During an interview on 04/16/24 at 1:52 PM, with the DON, she stated the cushion boots for Resident #1 should have been care planned and Resident #1 also wanted them on. The DON stated it was expected to be care planned for reimbursement and the risk of not care planning could be the wound not healing.</p> <p>Record review of the facility Comprehensive Care Planning policy not dated, revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the comprehensive assessment. The comprehensive care plan will describe the following -</p> <p>The services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary treatment and services based on the comprehensive assessment and consistent with professional standards of practice to promote healing and prevent worsening of pressure injuries for 1 (Resident #3) of 3 residents reviewed for pressure ulcers.</p> <p>The facility failed to provide proper wound care for Resident #1's facility acquired pressure ulcers to the right outer heel.</p> <p>This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 04/11/24, revealed, admission on 04/12/23 to the facility.</p> <p>Record review of Resident #1's significant change in status MDS assessment dated [DATE], revealed, he was cognitively intact to be able to make daily decisions and able to recall information with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 14. Resident #1 was diagnosed with Diabetes Mellitus, Pressure Ulcer of Sacral Stage 4, Pressure Ulcer of Unspecified site stage 4. Muscle wasting and atrophy (a joint disease, of which arthritis is a type). At risk for pressure ulcers. Resident #1 was marked down for having one or more unhealed pressure ulcers. Marked for pressure ulcer care. Care Area Assessment revealed care area trigger and care planning.</p> <p>Record review of Resident #1's care plan dated 04/10/24, revealed, has a pressure ulcer or potential for pressure ulcer development. Deep tissue injury to left and right heel. Administer medications as ordered. Administer treatment as ordered and monitor for effectiveness. Left heel: clean with normal saline, pat dry, apply collagen sheet and cover with bordered gauze dressing. Ensure heels are floated with the use of pillows.</p> <p>Record review of Resident #1's order recap dated 04/10/24, revealed, tissue injury to left heel: clean with normal saline, pat dry, apply collagen sheet, cover with gauze dressing, as needed and every day shift every Mon, Wed, Fri for wound care. Order dated 03/14/24, revealed, deep tissue injury to right heel: clean with normal saline, pat dry, apply betadine, cover with bordered gauze dressing, as needed and every day shift for wound care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/10/24 at 11:54 AM, with the Wound Care Nurse. Resident #1's right heel as it was being lifted did not have a dressing on it. The wound was exposed to the elements. The Wound Care Nurse with gloves grabbed a clean gauze and wiped right heel. The Wound Care Nurse then grabbed a 4 by 4 dressing and placed it on Resident #1's right heel. The dressing was sealed on Resident #1's skin. Cushion boots were put on and Resident #1 was covered with a blanket. The Wound Care Nurse did not date or initial both the dressing(s). The Wound Care Nurse was looking for the cushion boots and found them on the dresser. Resident #1 had pillows underneath his knees. The Wound Care Nurse told Resident #1 that he needed to have the cushion boots on as well to help heal his heels that had the pressure ulcers. Resident #1 stated he keeps telling the CNAs over and over and over again, but they do not put on the cushion boots</p> <p>During an interview on 04/10/24 at 12:18 PM, with the Wound Care Nurse, she stated Resident #1 did not have his wound dressing on his right heel and needed to have it on. The Wound Care Nurse stated she tells the nursing staff that if the wound dressing comes off to let her know to replace it with another dressing. The Wound Care Nurse stated the purpose of the dressing was to keep the Medi-honey or collagen on to heal the wound. The Wound Care Nurse stated not having the dressing on could worsen the wound by not letting it get better. The Wound Care Nurse stated she usually updates the dressing by labeling it with the date but did not have her marker to do it. The Wound Care Nurse stated the purpose of dating or labeling the dressing was so that the nursing staff knew when the dressings were changed. The Wound Care Nurse stated there was a risk of nursing staff not knowing the wound care was getting done if the dressing was not labeled and dated. The Wound Care Nurse, she stated the physician had given the order and it was a preventative measure. The Wound Care Nurse stated that physician orders needed to be placed for the cushion boots. The Wound Care Nurse did not answer if there would be a risk due to the Resident #1 already using them.</p> <p>During an interview on 04/11/24 at 8:59 AM, with CNA H, she stated when showering or moving residents that have pressure ulcers on their heels, the nursing staff if ordered has to put on the cushion boots once they are done moving or showering the resident. CNA H stated not putting on the cushion boots could result in the injury getting injured more.</p> <p>During an interview on 04/11/24 at 1:17 PM, with CNA E, she stated she would let the Wound Care Nurse know if the resident was missing a dressing so that they could replace it. CNA E stated having the dressing on would prevent infection. CNA E, she stated if a resident was required to have cushion boots on them then once the nursing staff has completed doing whatever they were doing with the resident, then they have to put back on the cushion boots. CNA E stated this was so no more pressure ulcers developed.</p> <p>During an interview on 04/16/24 at 1:52 PM, with the DON, she stated anytime wound care was conducted and dressings placed had to be labeled with dates and initials. The DON stated labeling the dressing would let the nursing staff know when the dressing(s) was changed. The DON stated the risk of not labeling and dating the dressings was the wound getting worse or infected. The DON stated the nursing staff are to be reapplying the wound dressings if they are off and missing. The DON stated again the risk would be infection if the dressing was not replaced.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/11/24 at 3:19 PM, with LVN G, she stated that cushion boots do not require a physician order as they are preventative measures. LVN G stated the purpose of physician orders was to indicate the treatment towards the resident. LVN G stated she would consider anything needing a physician order to be - medications, oxygen, transferring residents out of the hospital, wounds, and therapy. LVN G stated it would depend on the risk if not putting in the physician order. LVN G stated that assisted devices did need a physician's order.</p> <p>During an interview on 04/11/24 at 4:09 PM, with LVN D, she stated the nursing staff and the resident(s) with wound care should be telling the nurses if they are missing wound dressings so that they may be replaced. LVN D stated the purpose of the dressing was to make a barrier and not allow any new bacteria from getting in. LVN D stated that once the dressing was applied it needed to be dated and initialed. LVN D stated not labeling the dressing could have a negative impact on the wound's treatment. LVN D, she stated that there was no need to have physician orders for the cushion boots, as they could be considered a nursing intervention. LVN D stated she would consider the cushion boots to be an assistive device. LVN D stated from nursing school she was taught that cushion boots were used as a preventative which did not require a physician order.</p> <p>During an interview on 04/16/24 at 1:52 PM, with the DON, she stated anything that was a preventative measure that did not go inside the body does not require an order. The DON stated it was the facility's/company's policy to have physician orders for everything to be on the safe side. The DON stated the physician commented that a physician order was not warranted unless it was policy from the facility/company. The DON stated it was facility/company policy and the physician stated okay.</p> <p>Record review of the facility Dressing Changes policy dated 2003, revealed, Dressing changes will be completed to maintain sterility.</p> <p>Label the dressing with date, time, and initial.</p> <p>Record review of the facility Physician's Orders policy dated 2015, revealed, Purpose: to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and Activities of Daily Living order for each resident.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>45217</p> <p>Based on observations and interviews the facility failed to dispose of garbage and refuse properly for 2 (Dumpsters #1 and #2) of 2 dumpsters located outside of the facility.</p> <p>-Two dumpsters located outside the facility were open with their sliding doors open when not in use and trash was on the ground.</p> <p>These failures could place residents at risk of decreased quality of life due to an exterior environment which could attract pests, rodents, and other animals.</p> <p>Findings included:</p> <p>Observation on 04/11/2024 at 11:15 a.m., two dumpsters were observed outside the facility on the back of the property. Dumpster #1 was observed with the sliding door open. There were several pieces of trash on the ground outside of the dumpster. Dumpster #2 was observed with the sliding door open with trash reaching the height of the side door.</p> <p>Observation on 04/11/2024 at 12:59 p.m., two dumpsters were observed outside the facility on the back of the property. Dumpsters #1 and #2 were both observed with sliding doors opened. There were several pieces of trash on the ground outside of Dumpster #1.</p> <p>During an interview on 04/11/2024 at 1:17 p.m., CNA E said CNAs and Housekeepers throw away the trash from the resident rooms. CNA E said there were trash barrels in the hallways and if they were not available, they throw the trash in the dumpsters outside. CNA E said staff open the dumpster door to throw out the trash and then close it afterwards. CNA E said if the dumpster doors are not closed there is a risk of contamination, infection control, and attracting pests.</p> <p>During an interview on 04/11/2024 at 2:07 p.m., CNA F said briefs and gowns are bagged and thrown out in dumpsters behind the facility. CNA F said staff open the side door of the dumpster, throw the trash in, and then close the door. CNA F said the risk of failing to close the dumpster door was contamination and smells. CNA F said all staff who use the dumpster are responsible for ensuring the doors are closed and trash is picked up around the dumpsters.</p> <p>During an interview on 04/11/24 at 2:50 p.m., the DM said Maintenance is responsible for the dumpster. The DM said Maintenance was also responsible for picking up the trash around the dumpster area. The DM said the dumpster doors are to be kept closed when not in use. The DM said the risk of not having the dumpsters closed and the area cleaned thoroughly was rodents and attracting flies.</p> <p>During an interview on 04/16/24 at 8:45 AM, with the Maintenance Director, he stated that he was responsible for the trash on the ground near the dumpster but has been really busy with other work. The Maintenance Director stated the dumpster doors needed to be closed after throwing the trash away because it could invite pests. The Maintenance Director stated the trash on the floor ground could cause pests and roaches. The Maintenance Director stated it was everyone's responsibility to ensure the dumpster doors were closed.</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/16/24 at 1:52 PM, with the DON, she stated it was everyone's responsibility to pick up the trash off the ground near the dumpster. The DON stated the dumpster doors needed to be closed after every use. The DON stated not closing the dumpster doors or picking up the trash off the ground near the dumpster could attract roaches, bugs, and stray cats. The DON stated the risk would be infection.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 (Resident #11) of 6 residents reviewed for infection control.</p> <p>Resident #11's nasal cannula that was on the floor was placed back on Resident #11's nares (nostrils) without being replaced.</p> <p>This deficient practice could place residents at risk for infection due to improper care practices.</p> <p>Findings included:</p> <p>Record review of Resident #11's face sheet dated 04/11/2024, revealed a [AGE] year-old female who was originally admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #11's H&P dated 10/06/2023, revealed Resident #11's assessment included: Monitor O2 maintain adequate O2 saturation keep Sat>90%.</p> <p>Record review of Resident #11's MDS quarterly assessment dated [DATE], revealed a BIMS score of 00 indicating severe cognitive impairment. Section Special Treatments, Procedures, and Programs revealed resident on oxygen therapy.</p> <p>Record review of Resident #11's Order Summary Report dated 04/11/2024, revealed an order may use oxygen at 2 liter per minute via nasal cannula every shift, with order start date of 03/28/2024.</p> <p>Observation and interview on 04/11/2024 at 8:38 a.m., Resident #11 was observed lying in bed without her nasal cannula on. LVN D entered the room and noted that the nasal cannula was on the floor. LVN D picked up the nasal cannula off the floor and put it back on Resident #11's face. LVN D was asked about the cannula being on the floor and LVN D said she should have grabbed another canula for infection control reasons. LVN D said it was her mistake and she does not have an excuse for making the mistake.</p> <p>During an interview on 04/11/2024 at 1:17 p.m., CNA E said if a nasal canula was found on the floor, the CNA staff report it to the nurse so that the nurse can change the cannula because it was contaminated. CNA E said it would not be right if a staff or nurse put on the same contaminated cannula placing resident at risk of infection.</p> <p>During an interview on 04/11/2024 at 2:07 p.m., CNA F said if the cannula is on the floor it needs to be changed because it is dirty and needs to be thrown away and a new one needs to be put on. CNA F said she would let the nurse know if the cannula was on the floor.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER El Paso Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11525 Vista Del Sol Dr El Paso, TX 79936	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/11/2024 at 3:19 p.m., LVN G said if a nasal cannula is found on the floor, it should be discarded and a new one put in place because the floor is dirty. LVN G said the risk was infection control.</p> <p>During an interview on 04/11/2024 at 4:09 p.m., LVN D said if a cannula is found on the floor it was the responsibility of facility nurse is to replace it. LVN D said the risk of using the cannula that was on the floor was inviting bacteria into the body and infection control.</p> <p>Record review of facility provided Oxygen Administration policy dated 03/21/2023, reads in part, change the tubing that is in use on one patient when it malfunctions or becomes visibly contaminated.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>The facility did not ensure the floors and ceilings were not stained, floor tiles were not broken/missing, restroom faucet(s) had running water, restroom(s) light bulbs were not out, there was not a strong urine smell in B-Hall, in a living area there was not trash on the floor, the wall under the medical records room/oxygen room did not have a huge hole, and hot water was available in C-hall, Room B105 had wet urine in the restroom and in the room, strong urine smell, there was wet pieces of toilet paper all over the room. Medical Records room had a hole in the wall, resident phone room had a hole in the wall, D-Hall had broken tile on the floor.</p> <p>These failures placed residents and staff at risk of living, working, and visiting in an unsafe, unsanitary, and uncomfortable environment.</p> <p>Findings include:</p> <p>Record review of Resident #3's face sheet dated 08/25/22, revealed admission on 08/25/22 and re-admission on 07/10/23 to the facility.</p> <p>Record review of Resident #3's facility history and physical dated 07/11/23, revealed, a [AGE] year-old male diagnosed with a history of falls, contusion (another word for a bruise-a collection of blood not in a blood vessel) of other part of head, cerebral (brain) edema (swelling caused by too much fluid trapped in the body's tissues), non-traumatic intracranial hemorrhage (bleeding into the brain), contusion (an injury to the brain that results in temporary loss of normal brain function) and laceration to cerebrum, concussion with loss of consciousness of 30-minutes or less.</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE], revealed, a moderately impaired cognition to be able to recall or make daily decisions BIMS (test used to get a quick snapshot of how well you are functioning cognitively at the moment) score of 9. Activities of daily living revealed resident required supervision or touching assistance from facility staff for toileting. Resident #3 was always continent. Resident was diagnosed with traumatic brain injury, Non-Alzheimer's Dementia, Cerebrovascular Accident, blindness one eye, muscle weakness (no muscle strength). Resident #3 has had on e fall since admission.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan dated 07/19/23, revealed, activities of daily living to be at risk of self-care performance of not having his needs met in a timely manner . Toileting was to be supervision with set-up. Ambulation: front wheel walker - supervision with set-up. Care Plan dated 07/10/23, revealed, resident was incontinent of bowel/bladder. Resident #3 will urinate in the toilet and tends to urinate on the floor. Revision was made on 04/09/24, when surveyors made facility aware - Monitor for floor wetness, if wet, staff to clean up. Care Plan dated 07/19/23, revealed, ensure that the resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair. Educate the resident/family/caregivers/ about safety reminders and what to do if a fall occurs. Care Plan dated 03/25/24, revealed, impaired visual function. Identify/record factors affecting visual function including physiological (glaucoma, cataracts, color discrimination, dry eyes) and environment (poor lighting).</p> <p>Observation on 04/09/24 at 9:56 AM, in B-hall revealed it smelled of strong urine. Room B105 floor had streaks, stains, and wet toilet paper on it. There were wet pieces and tears of toilet paper leading from the restroom to Room B105 bed and nightstand. The room was strong with urine smell and the floor when stepping on it was sticky. In the restroom the floor was wet, damp, and stained (toilet was checked for leaks and it was not leaking, it was urine).</p> <p>Observation on 04/09/24 at 10:05 AM, in B-hall, revealed, on the floor dark spots/drips and streaks of unknown substance. Further down B-hall on the floor was a long 5-6 inch by 1-2-inch reddish orange stain(s). Several dark spots/drips of unknown substance were on four different floor tiles.</p> <p>Observation on 04/09/24 at 10:41 AM, in C-hall, revealed, on the floor several lines of drops/drips of dark reddish/maroon unknown substance of various different diameters. In room C114, underneath a bed with a resident on top there was wet toilet paper on the floor. The bottom border of the hallway wall was coming off. In room C106 the restroom faucet has no running water, and 1 out of 2 light bulbs was out on the lights above the mirror. There were three dots on the ceiling of different sizes from penny size to quarter that were reddish brown of an unknown substance.</p> <p>Observation on 04/10/24 at 10:41 AM, in the Medical Records room revealed a 2 foot by 2-foot hole exposing the yellow insulation towards the bottom of the wall with light coming from the other side of the room (Oxygen Room). A portable oxygen tank holder could be seen. A square foot tile and pieces of the surrounding tiles was missing exposing dirt. Observation of D-hall , revealed, In the phone room towards the bottom of the wall was a large 6 inch by 12-inch hole exposing the inside structure. Broken floor tile was missing outside of Room D101.</p> <p>Observation on 04/11/24 at 10:17 AM, with Maintenance Director, in room B110 revealed, the hot water when turned on was not flowing and was leaking from underneath the sink.</p> <p>During an interview on 04/08/24 at 10:13 AM, with CNA L, she stated Resident #3 tends to urinate everywhere in the room. CNA L stated housekeeping cleans the urine but did not know if they had been called to clean it up. CNA L stated the facility staff have been cleaning up the urine from the floor but because Resident #3 keeps urinating on the floor they cannot get the smell out. CNA L stated they clean and clean but after they clean the floor ends up being urinated on.</p> <p>Observation on 04/08/24 at 1:52 PM, revealed, Resident #3's room was clean but still had a strong odor of urine that could be smelled from the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/08/24 at 11:19 AM, with the Maintenance Director, he stated C-hall did not have hot running water. The Maintenance Director stated the circulating pump was installed backwards by the previous Maintenance Director K. The Maintenance Director stated when he reinstalled the circulating pump correctly in December 2023, the pipes erupted and C-hall had several rooms that the slab starting leaking water and had to turn off the water.</p> <p>During an interview on 04/16/24 at 1:52 PM, with the DON, she stated the nurse's staff are trained on how to put in work orders. The DON stated sometimes staff need to be re-educated on putting in orders instead of telling the Maintenance Director verbally. The DON stated the risk of not placing work orders in would be that the broken items would not get fixed or addressed. The DON stated the water temperature at the facility has been working sometimes and sometimes it did not work since she has been at the facility and that had been close to 1 1/2 years now. The DON stated the previous Maintenance Director K had installed the circulating pump backwards and when the Maintenance Director fixed it, it busted the pipes on the floor in C-hall. The DON stated the residents from C-hall were taken to shower in the communal showers in A-hall.</p> <p>Record review of facility Maintenance Log dated 01/01/23 to 04/09/24, revealed, no work orders for the Medical Records/Oxygen Room(s), Phone Room, C106 light bulb out, B110 underneath sink water leaking, the broken tile.</p> <p>08/12/23, 08/13/23 - Not able to make out initials of reporter - In C & D-Hall(s) there was no hot water. Comment made by unknown writer - Working on it.</p> <p>08/24/23 - CNA I reported - in C-Hall there was no hot water in the shower. Comment made by unknown writer - Waiting on quotes.</p> <p>08/25/23 - CNA J reported - in A & D-hall there was not hot water. Comment made by unknown writer - waiting on quotes.</p> <p>09/16/23 - CNA I reported - in C-Hall that there was no hot water in the shower room. Comment made by unknown writer - indicated working on it.</p> <p>Record review of the facility Deep Cleaning Process-Resident Room policy dated 2015, revealed, follow the cleaning procedures in the Housekeeping training Manual for using appropriate products can help you keep the room as sanitary as possible. Only use the provided pre-mixed chemical products provided by the supplier.</p> <p>Floors: dust mop and wet mob entire room by starting at the entrance, move straight to the back of room and use the figure 8 motion to work your way back to the door.</p>		