STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455935	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Paso Health & Rehabilitation Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #1) of 8 residents reviewed for call light placement. -The facility failed to ensure that Residents #1's call light was within his reach. This failure placed residents at risk of not being able to call for assistance when needed. Findings included: Review of Resident #1's Admission Record dated 09/13/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture), depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), muscle weakness, lack of coordination, intellectual disability (deficits in theoretical thinking/learning), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and paraplegia (paralysis that affects your legs, but not your arms). Review of Resident #1's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 indicating moderate cognitive impairment. Section GG - Functional Abilities and Goals section revealed Resident #1 requires substantial/maximal assistance with toileting, showering, dressing, personal hygiene, and dependent for transfers. Section J - Health Conditions indicates Resident #1 had not had any falls since admission/entry or reentry or the prior assessment. Review of Resident #1's care plan dated 09/13/2024, reads in part Resident #1 had a communication problem related to Intellectual Disabilities as evidenced by slurred and mumbled speech. Part of the interventions included Ensure/provide a safe environment: Call light in reach. Another focus area reads in part that Resident #1 was risk for falls related to gait/balance problems. Part of the interventions included Be sure the resident's call light is within reach and encourage the resident to use it. Another focus area reads in part that Resident #1 had impaired visual function and was at risk for falls, injury, and a decline in functional ability. Part of the interventions included Anticipate needs and meet them as able. Keep call light in reach when in room or bathroom. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/13/2024 at 10:52 a.m., Resident #1 was lying in bed. Resident #1's call button was observed on top of a bed side dresser located next to a second unoccupied bed in the room, approximately four feet away from Resident #1. Resident #1 said he was not able to get up from bed on his own. Resident #1 said he was not able to reach the call button. Resident #1 said he did not know why his call button was out of reach. Resident #1 said he did not know how long the button was out of his reach. Resident #1 said he had not had any falls. During an observation and interview on 09/13/2024 at 11:00 a.m., LVN G entered Resident #1's room and said Resident #1 was able to use a call button when needing something. LVN G observed Resident #1's call button was out of his reach. LVN G said Resident #1's call button was out of reach, and he would not be able to get up to get his call button since he was not able to get up from bed on his own. LVN G said Resident #1 was a fall risk and had not had any recent falls that she was aware of. LVN G said she did not know how long Resident #1's call button had been out of reach. LVN G said Resident #1 had received patient care 15 to 20 minutes before and most likely the CNAs failed to return his button within reach of Resident #1. During an interview on 09/17/2024 at 1:20 p.m., the DON said the purpose of a call light was to alert nursing staff and CNAs that resident assistance was needed. The DON said Resident #1 was able to use a call button to call for assistance. The DON said Resident #1 had limited mobility. The DON said the risk of having the call button out of reach was a possible delay in emergency assistance for the resident, or resident's needs being met. The DON said it was the responsibility of all staff in the hall to ensure that the resident's call button always remains in reach when he was in bed. Surveyor requested a copy of the call light policy. During an interview on 09/17/2024 at 2:20 p.m., the Administrator said the purpose of a call light was for residents to ask for help and to get staff's attention. The Administrator said there was a risk that residents would not be able to call for help if the call button was not in reach of the resident. The Administrator said Resident #1 was able to use a call button and the button must be always within his reach. Surveyor requested a copy of the call light policy. Review of an undated facility provided Resident Rights policy, reads in part the resident had a right to receive the services and/or items included in the plan of care. On 09/17/2024 at 3:30 p.m., the requested copy of call light policy was not provided prior to exit.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 7 residents reviewed for care plans. -The facility failed to follow the comprehensive person-centered care plan for Resident #1's fall risk, by failing to have a fall mat in place next to bed while resident was lying down in bed. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services as indicated in their comprehensive person-centered plans developed to address their needs. Findings include: Review of Resident #1's Admission Record dated 09/13/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture), depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), muscle weakness, lack of coordination, intellectual disability (deficits in theoretical thinking/learning), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and paraplegia (paralysis that affects your legs, but not your arms). Review of Resident #1's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 indicating moderate cognitive impairment. Section GG - Functional Abilities and Goals section revealed Resident #1 was dependent for transfers. Section J - Health Conditions indicates Resident #1 had not had any falls since admission/entry or reentry or the prior assessment. Review of Resident #1's Order Summary Report dated 09/13/2024, revealed an order for a Fall mat while in bed two times a day for prevention of injury. Review of Resident #1's care plan dated 09/13/2024, reads in part, focus area with initiated date of 08/09/2024, Resident #1 had the potential for falls related to impaired mobility, such as cerebral palsy, paraplegia, seizures and intellectual disabilities. Part of the interventions included fall mat while in bed. During an observation and interview on 09/13/2024 at 10:52 a.m., Resident #1 was lying in bed. Fall mat noted leaning against a dresser located approximately six feet away from Resident #1's bed. Resident #1 said he did not know why the fall mat was away from the side of the bed. Resident #1 said he did not know who put the mat leaning up against the dresser. Resident #1 said he did not know how long the mat was leaning up against the dresser and not on the side of his bed. Resident #1 said he had not had any falls that he was aware of. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/13/2024 at 11:00 a.m., LVN G entered Resident #1's room and said Resident #1 was a fall risk and should have a fall mat next to the bed when he was in bed. LVN G observed fall mat leaning up against the dresser approximately six feet away from Resident #1's bed. LVN G said it had been months since Resident #1 had a fall from her recollection. LVN G placed the fall mat next to Resident #1's bedside (other side of the bed was against the wall). LVN G said she did not know how long Resident #1's fall mat was not next to his bed. LVN G said Resident #1 had received patient care by CNAs about 15 to 20 minutes before and most likely the CNAs failed to return the fall mat next to Resident #1's bed. During an interview on 09/17/2024 at 1:20 p.m., the DON said the purpose of a care plan was to individualize a plan of care to address resident needs, behaviors, psychosocial needs, and other things like falls and other risks. The DON said the purpose of a fall mat was to reduce injuries. The DON said Resident #1 was a fall risk and failing to follow his plan regarding having a fall mat increased the risk of injury and/or severity of injury. The DON said it was all floor staff responsibility to follow the care plan and ensure interventions are implemented. During an interview on 09/17/2024 at 2:20 p.m., the Administrator said the purpose of a care plan was to let staff know how to take care of a resident. The Administrator said the purpose of a fall mat was to be used as a protective barrier to prevent injury. The Administrator said failure to follow the care plan for Resident #1, who was a fall risk, could place him at a higher risk of injury. The Administrator said staff on the floor have access to the resident care plans and are responsible for following the care plan. Review of facility-provided Comprehensive Care Planning policy undated, reads in part Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview and record review the facility failed to review and revise Resident Care Plans after each assessment for 1 (Resident #1) of 8 residents whose records were reviewed. -Resident #1's Care Plan was not updated to reflect discontinuation of padding the wall. These deficient practices could lead to errors in treatment and services provided based on incorrect information. Findings included: Resident #1: Review of Resident #1's Admission Record dated 09/13/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture), depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), muscle weakness, lack of coordination, intellectual disability (deficits in theoretical thinking/learning), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and paraplegia (paralysis that affects your legs, but not your arms). Review of Resident #1's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 indicating moderate cognitive impairment. Section E - Behavior revealed Resident #1 had not exhibited any physical, verbal or other behavioral symptoms. Review of Resident #1's care plan dated 09/13/2024, reads in part Resident #1 had history of behavior problem as evidenced by resident will hit the wall with his hand. Part of the interventions included Place padding on wall to cushion the resident's hand in case the behavior continues. During observation and interview on 09/16/2024 at 10:47 a.m., Resident #1 was observed lying in bed. One side of his bed was against the wall. The wall was noted without any padding. Resident #1 said he had moved to the room from another room last week but could not remember the date. Resident #1 said he did not need any padding for the wall as he did not hit the wall. Resident #1 said he did not know what instructions were written on his care plan regarding padding on the wall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/2024 at 10:05 a.m., ADON C said Resident #1's care plan still shows that wall should be padded. ADON C said the intervention step was in place in 2021 as Resident #1 had exhibited behaviors and hit the wall. ADON C said the care plan intervention step was no longer applicable as Resident #1 had not exhibited the behavior anymore since 2021, and the intervention should have come off his care plan. ADON C said Resident #1's care plan should have been updated and she did not know why the intervention was not taken off the care plan. ADON C reviewed Resident #1's injury history and noted there had been no injuries resulting from Resident #1 hitting the wall from 01/01/2023 to 09/17/2024. ADON C said the care plan should have been updated by nursing or the MDS department. During an interview on 09/17/2024 at 1:03 p.m., the MDS Coordinator said the purpose of the care plan was to address what the resident needs. The MDS Coordinator said the care plan not being accurate or up to date could result in confusion. The MDS Coordinator said social services, nursing and MDS department were able to update the care plans. The MDS Coordinator said the care plan should be reviewed quarterly and whenever there was a change of condition to make sure information was accurate. The MDS Coordinator said Resident #1 did not have an order for a padded wall and that it was a precautionary part of the care plan. The MDS Coordinator said when it was determined that Resident #1 did not require the padding on the wall, it should have been removed from the care plan. The MDS Coordinator said nursing or social services could have removed the intervention step. The MDS Coordinator said it appeared that the intervention step carried over from 2021 and was overlooked for revision. During an interview on 09/17/2024 at 1:20 p.m., the DON said the purpose of a care plan was to individualize a plan of care to address resident needs, behaviors, psychosocial needs, and other things like falls and other risks. The DON said the risk of care plans not being revised timely was confusion or providing the wrong type of services. The DON said care plans should be revised immediately or at least the following day when a change in the plan was identified. The DON said nursing services and MDS should revise the care plan as needed. The DON said there was no oversight on revisions and would begin an audit immediately. During an interview on 09/17/2024 at 2:20 p.m., the Administrator said the purpose of a care plan was to let staff know how to take care of a resident. The Administrator said not revising a care plan timely could result in confusion in care of resident regarding if an intervention was still needed. The Administrator said nursing, MDS, and social services are responsible for updating and ensuring the care plan is accurate. Review of facility-provided Comprehensive Care Planning policy undated, reads in part Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #1) of 7 residents reviewed for assistance with ADLs. -The facility failed to ensure Residents #1's fingernails were trimmed and cleaned. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk of infection, and decreased quality of life. Findings include: Review of Resident #1's Admission Record dated 09/13/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture), depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), muscle weakness, lack of coordination, intellectual disability (deficits in theoretical thinking/learning), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), and paraplegia (paralysis that affects your legs, but not your arms). Review of Resident #1's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 indicating moderate cognitive impairment. Section GG - Functional Abilities and Goals section revealed Resident #1 requires substantial/maximal assistance (level of assistance where a helper provides more than half of the effort for a task) with toileting, showering, dressing, and personal hygiene. Review of Resident #1's care plan dated 09/13/2024, reads in part Resident #1 had potential/actual impairment to skin integrity related to fragile skin due to contractures. Part of the interventions included avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Another focus area includes Resident #1 had ADL self-care performance deficit and was at risk for not having needs met in timely manner. Part of the interventions included provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During observation and interview on 09/16/2024 at 11:05 a.m., Resident #1 was lying in bed. Observed Resident #1 scratch right side of face and noted fingernails on right hand were long and dirty. Nails were approximately 2 cm long and jagged. There was brown/black discoloration noted under the nails. Resident #1 said he did not know the last time his nails were trimmed or filed. Resident #1 said he would like his nails trimmed because they were too long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 09/16/2024 at 2:45 p.m., LVN I entered Resident #1's room and observed his nails. LVN I said the resident's nails were a little long, jagged, and dirty. LVN I said the CNAs take care of nail care for Resident #1 during showers or as needed. LVN I said she did not know when was the last time Resident #1 had his fingernails trimmed or filed. LVN I said there was a risk Resident #1 may scratch himself causing skin tear and possible infection from dirty nails. Resident #1 told LVN I that he wanted his nails cut. During an interview on 09/17/2024 at 9:54 a.m., LVN G said nail care was usually done on Sundays or as needed. LVN G said generally the CNAs will take care of nail care but if they are busy, they will let the nurses know and the nurses can trim and file the nails. LVN G said she worked from Friday through Sunday, and no one mentioned anything about Resident #1's nails being long or dirty. During an interview on 09/17/2024 at 1:20 p.m., the DON said the purpose of fingernail care was to avoid someone scratching themselves, skin issues, and infection control if there are dirty nails. The DON said the risks of a person dependent on ADLs having long and dirty fingernails was scratching and/or possible infection. The DON said nail care should be done on Sundays and could be done either by the aides or a nurse. During an interview on 09/17/2024 at 2:20 p.m., the Administrator said the purpose of fingernail care was to minimize the risk of scratching and skin tears. The Administrator said that nail care could have been performed by aides and nurses as needed. Record review of facility policy titled Nail Care dated 2003, reflected in part Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails . Goals: Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #3) of 4 residents reviewed for gastrostomy tube management quality of care. -The facility failed to ensure Residents #3 was provided with the correct feeding through gastrostomy tube (g-tube, feeding tube) as ordered per physician. This failure could place residents who received feedings by gastrostomy tube at risk for decline in health and weight loss. Findings included: Review of Resident #3's Admission Record dated 09/13/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included cerebral infarction (lack of oxygen to the brain causing damage to brain tissue), unspecified protein-calorie malnutrition, dysphagia (swallowing difficulties), and gastrostomy status (a feeding tube that delivers nutrition to your stomach). Review of Resident #3's quarterly MDS assessment dated [DATE], revealed a BIMS score of 00 indicating severe cognitive impairment. Section GG - Functional Abilities and Goals revealed Resident #3 is dependent on staff for toileting, showering, dressing, and personal hygiene. Section K - Swallowing/Nutritional Status revealed Resident #3's nutritional approach was feeding tube. Review of Resident #3's Order Summary dated 09/17/2024, revealed enteral feed order in the morning start continuous enteral feeding. Start at 0600 and run until midnight. Hold feeding from 0000 (12:00 a.m.) to 0600 (6:00 a.m.). Review of Resident #3's care plan dated 09/17/2024, revealed Resident #3 required tube feeding related to dysphagia. Part of the interventions included resident was dependent with tube feeding and water flushes; see MD orders for current feeding orders. Observation on 09/16/2024 at 1:45p.m., revealed Resident #3 was lying in bed asleep with head of bed elevated. There was tubing with Jevity 1.2 (liquid nutritional supplement that can be used for tube feeding or oral consumption) connected to a feeding pump on a pole next to Resident #3's bed. Continuous feed pump was turned off. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/16/2024 at 2:46 p.m., revealed Resident #3 was lying in bed asleep with head of bed elevated. There was tubing with Jevity 1.2 connected to a feeding pump on a pole next to Resident #3's bed. Continuous feed pump was turned off. LVN I entered the room and noted the feed machine was off. LVN I said Resident #3 was on continuous enteral feeding during the day and did not know why the machine was turned off. LVN I said the CNAs had provided patient care to Resident #3 over an hour ago and may have turned off the machine. LVN I said no one told her the machine was turned off. LVN I began to assess the resident. LVN I said Resident #3 was not in any distress. LVN I said Resident #3 had not had any significant weight loss. LVN I said Resident #3's vitals were at baseline for the resident. Review of Resident #3's weight records revealed initial weight taken on 06/21/2024 was 130.0 lbs. The latest weight taken on 09/10/2024 was 129.6. During an interview on 09/17/2024 at 1:20 p.m., the DON said the purpose of enteral feeding was to give someone nutrients and calories that are required as they can no longer eat for themselves. The DON said the risk of failing to follow the orders and the feeding machine being turned off, if it were a recurring thing, would be a loss of weight, and malnutrition. The DON said an isolated incident would not necessarily have the same risk but needs to be addressed with staff to ensure it does not become a recurring issue. The DON said nursing staff are responsible to ensure that orders are being followed for residents. During an interview on 09/17/2024 at 2:20 p.m., the Administrator said the purpose of enteral feeding was to provide nutrition to the resident. The Administrator said failure to follow orders for continuous feeding could result in the resident not receiving the required nutrition and caloric intake. The Administrator said nursing staff are responsible for following orders and resident care plan. Record review of facility policy titled Enteral Nutrition dated 02/13/2007, reflected in part the facility will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth. The Nursing Services Department is responsible for all feeding equipment and the administration of tube feedings. Problems with the administration of the tube feeding are monitored and corrected by nursing.