

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 09/23/2024
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 49850</p> <p>Based on observations, interviews, and record review the facility failed to ensure resident#1 was free from any physical or chemical restraints imposed for purposes of discipline or convenience for one (Resident #2) of five residents reviewed for freedom from physical restraints.</p> <p>The facility failed to ensure Residents #2 did not have pillows under his mattress which restricted his movement from getting off the bed and were not required to treat his medical symptoms.</p> <p>This failure could put residents at risk of unnecessary restriction of their movements.</p> <p>Findings included:</p> <p>Resident #2</p> <p>Record review of Resident #2's Admission Record revealed he was a [AGE] year-old male who was admitted on [DATE] with diagnoses including paroxysmal atrial fibrillation (irregular heartbeat), atherosclerosis (with rest pain bilateral legs, type 2 diabetes, hyperlipidemia (high cholesterol), unspecified dementia without behavioral disturbance, hypertension, vascular disease, and shortness of breath.</p> <p>Record review of Resident #2's History and Physical dated 09/14/2024 did not have any documentation as the resident was just admitted into the facility on [DATE].</p> <p>Record review of Resident #2's MDS dated [DATE] did not have anything documented as it was still pending completion due to him being a new admit.</p> <p>Record review of Resident #2's care plan, dated 09/14/2024, had no documentation regarding if the resident had any behavioral issues trying to get out of bed. The only focus that was set for the resident was the use of anxiety medication, with a goal that Resident #2 will be free from discomfort or adverse reactions related to anxiety therapy, with interventions of an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, fall, broken hips and legs, and monitor for safety.</p> <p>Record review of Resident #2's order recap report dated 09/14/2024 revealed a floor mat or other fall prevention device was ordered.</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 - Few</p>	<p>In an observation on 09/20/2024 at 09:55 AM Resident #2 was lying in bed with about three pillows underneath his mattress. The pillows were placed on the left side under the resident's mattress causing the mattress to lean more towards the right side. Resident #2 could not verbalize complete sentences and mumbles words.</p> <p>In an interview on 09/21/2024 at 10:00 AM CNA A, stated the pillows were put that way so he did not roll off the bed. He was always falling and if the pillows were placed under the mattress, then the resident was unable to roll to the floor. She stated that was how they've done it for a while, and no one has told her differently.</p> <p>In an interview on 09/20/2024 at 11:13 AM RN A said that she just started here about 3 weeks ago and it was brought up to her attention by CNA A. RN A advised CNA A that it was not right and had her remove the pillows immediately. RN A educated CNA A and advised CNA A that there needed to be an order in place and there was not, so she needed to remove them, that it was a restraint. Resident #2 now does not have pillows under the mattress. RN A stated she always removed them if she sees that but believed CNA A has been doing it for a long time prior to her starting here.</p> <p>In an interview on 09/20/2024 at 11:23 am, the DON was shown the picture of Resident #2 and how the pillows where under his mattress. The DON has been employed with facility since July 15, 2024. Stated the pillows underneath the mattress was not considered appropriate and did not know that staff were doing that. She stated if she knew that, she would have had them immediately take it off and in-service the staff. It was usually the same aid during the day all week-long until nighttime the facility would have a different one. She stated everyone has been in-serviced and the weekend staff will be as well.</p> <p>On 09/21/2024 at 11:48 am an interview was conducted with ADON A and ADON B. ADON B has been employed with facility for 7 years and ADON A has been employed for [AGE] years with the facility. The same picture of Resident #2's pillows under the mattress were shown to both the ADON's. They both stated it was considered a restraint. They stated Resident #2 just arrived 2 weeks ago (more or less) and they stated they do educate their CNA's on ANE, Falls, and restraints. The last in-service was this past week, and they also have it on digital training system every year. ADON A can't recall if CNA A signed the in-service but did do the digital training system. She stated the resident had a consent form filed out by hospice and signed by family for bed rails, but they were taken off because he was not using them for repositioning. Staff knew it was a restraint free facility, and bed rails were only used for bed mobility. The resident wasn't using them, he was not able to move himself much, and the resident was not able to verbally communicate. The bed rails were removed last week, nursing staff removed them, called hospice, informed the family, did the assessment, and completed a consent while they were there. ADON B was not aware CNA A was placing the pillows like that. The CNAs usually work on their own, but the team nurses rotate so there was no same nurse on the same hallway all the time. There were 4 nurses on the floor right now, they should do rounds every 2 hours, at the beginning of the shift and on the off going shifts. ADON B couldn't say if they did it today since it was not seen. CNA A has been here about 3 years, they all know they were not supposed to do that.</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 - Few</p>	<p>In an interview on 09/21/2024 at 12:05pm, CNA A, stated she's had multiple in-services on restraints and knows what a restraint was. She stated this was the first time that she has done this because she knew better. She stated that RN A was the one that told her this morning to do that. She knew that it was wrong but because her nurse told her to, she listened. She knew that she was to put the bed at a low position and have the floor mat on the floor only if they were a fall-risk or depending on the orders.</p> <p>Review of the facility policy Restraint revised February 1, 2007, states it is the policy of this facility to maintain an environment that prohibits the use of restraints for discipline of convenience. The facility is committed to nurturing the autonomy and independence of our residents by attempting to provide a restraint-free environment.</p>