

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  01/15/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43871</p> <p>Based on observation, interview and record review, the facility failed to maintain housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior for 1 of 6 resident rooms, observed for housekeeping and maintenance, in that:</p> <p>The facility failed to ensure CNA E used the facility work order system to input the lights in the restroom and room of Resident #5 would not turn on while Resident #5 wanted to use the restroom but was dark and could not see.</p> <p>These failures could lead to resident injury and a diminished quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #5's face sheet dated 01/15/25, revealed, admission on 02/01/20, re-admission on 10/15/21, and re-admission again on 02/22/22 to the facility.</p> <p>Record review of Resident #5's facility history and physical dated 07/28/24, revealed, a [AGE] year-old female diagnosed with Anxiety, Cholecystitis (inflammation of the gallbladder), reduced mobility, history of falls, and GI bleeding (bleeding from any part of the digestive tract, from the mouth to the anus).</p> <p>Record review of Resident #5's annual MDS dated [DATE], revealed, little to no impairment of cognition BIMS score of 15 and to be able to recall or make daily decisions. ADLs revealed to be independent for toileting, shower/bath, dressing. Independent for walking 10 feet/50 feet.</p> <p>Record review of Resident #5's Care Plan dated 04/27/22, revealed the resident was incontinent of bowel/bladder related to history of UTI, confusion, and incontinence. Maintain unobstructed path to the bathroom. Resident #5 had impaired visual function and was at risk for falls, injury, and a decline in functional ability. Anticipate needs and meet them as able. Keep call light in reach when in room or bathroom. Involve in activities which do not require vision to participate such as music, parties, and exercise. Monitor and report eye problems, change in ability to perform ADLs, decline in mobility, sudden visual loss, tunnel vision, blurred vision, hazy vision. Resident #5 was able to see large print in a well illuminated room. ADLs was supervision with set-up for toileting due to impairment with balance coordination.</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>Observation and interview on 01/15/25 at 8:44 AM, with Resident #5, she stated she was looking for staff due to her lights in her restroom and room not turning on. Resident #5 showed state agency her room and tried to turn on the light switch in the room. It was observed that the light in the room was not turning on. Resident #5 stated she had to go to the restroom, but could not cause the light in the restroom would not turn on and was afraid to go to the restroom without the lights turning on. State agency tried turning on the lights in the restroom and would not turn on. It was observed that the room was dark, and, in the restroom, it was dark and darker if the restroom door was closed. It was observed that nothing could be seen if the restroom door was closed. Resident #5 had stated she told a nursing staff about the issues a little over an hour ago and did not know what had happened.</p> <p>In an interview on 01/15/25 at 8:48 AM, with CNA E, she stated Resident #5 had told her about the lights not turning on in her room and restroom. CNA E stated she was looking for the floor charge nurse of the hall at the nurse's station and could not find her. CNA E stated since she was not able to find her, she went back to assist another resident with feeding as she was busy. CNA E stated she did not use the facility work order system to input the work order. CNA E stated she had been trained to use the facility work order system when facility needed to report facility stuff that needed fixing and tell the nurse. CNA E stated the risk of the lights not working for Resident #5 could have been a fall.</p> <p>Observation on 01/15/25 at 8:50 AM, revealed, visible facility work order system QR Scan postings in around the nurse's station of the facility.</p> <p>In an interview on 01/15/25 at 9:19 AM, with the Maintenance Director, he stated facility staff have been trained to use the facility work order system and what to do if they see, hear, or get reported facility stuff that were broken. The Maintenance Director stated there were QR Scan codes posted everywhere in the facility in which facility staff could place the work orders through there phones. The Maintenance Director stated not using the facility work order system could have a negative outcome of broken item(s) not getting fixed affecting the resident negatively depending on the situation. The Maintenance Director stated he was told of Resident #5's lights not turning on around 10 minutes ago which he observed that the lights were not turning on. The Maintenance Director stated Resident #5 told him she wanted them to turn on. The Maintenance Director stated an issue like the lights not turning on for Resident #5 was considered to be a 911 call (defined as notify the Maintenance Director immediately with clogged toilet, lights out, Exit lights out, etc.) and should have inputted into the facility work order system and told immediately.</p> <p>In an interview on 01/15/25 at 10:49 AM, with ADON C and ADON D, ADON C stated all facility staff were trained on how to place a work order. ADON D stated there were QR Scan code postings throughout the facility in which facility staff could use the facility work order system to place work orders which was sent to the maintenance department. ADON C stated if nursing staff were reporting a work order issue and cannot find the nurse, then they need to directly let the Maintenance Director know aside from using the facility work order system. ADON D stated the risk would depend on the situation.</p> <p>(continued on next page)</p>		

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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>In an interview on 01/15/25 at 11:13 AM, with the Administrator, she stated facility staff were trained on the facility work order system on how to place work orders in. The Administrator stated the maintenance department should be reviewing the work orders daily. The Administrator stated the risk of not using the facility work order system could result in the broken item not being forgotten and would not be fixed. The Administrator stated the risk to the resident would depend on the situation.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43871</p> <p>Based on the observation, interview, and record review, the facility failed to ensure that the residents environment remains free of accidents hazards as possible and each resident receives adequate supervision to prevent accidents for 1 (Resident #3) of 3 residents reviewed for accidents and supervision.</p> <p>The facility failed to ensure CNA A secured the brakes on a mechanical lift when lifting and lowering Resident #3 to bed.</p> <p>This failure could place residents at risk for falls or injury.</p> <p>The findings included:</p> <p>1. Record review of Resident #3's face sheet dated 1/14/25 revealed a [AGE] year-old female was readmitted to the facility on [DATE].</p> <p>Record review of Resident #3's history and physical dated 11/27/24 revealed diagnoses of diabetes (blood sugar is too high), hypertension (high blood pressure), pulmonary embolism (blood clot that blocks and stops blood flow to an artery in the lung), and an unstageable pressure ulcer of the heel.</p> <p>Record review of Resident #3's significant change in condition MDS assessment dated [DATE] revealed a BIMS score of 15, indicating her cognition was intact. The resident was dependent on staff for transfers.</p> <p>Record review of Resident #3's care plan dated 10/16/24 revealed a focus area of ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner and interventions that included assist x 2 (two people) with transfers, use mechanical lift.</p> <p>In an observation on 1/14/25 at 1:28 pm, CNA A and CNA B assisted with perineal care and performed a mechanical lift transfer for Resident #3. During the transfer, the brakes on the mechanical lift were not engaged, causing the lift to move slightly. The resident was moved over the bed, with CNA A maneuvering the mechanical lift and CNA B assisting. The brakes were also not secured when lowering the resident onto the bed.</p> <p>In an interview on 1/14/25 at 2:01 pm, CNA B stated that she had received training on how to properly hook the sling and secure brakes on mechanical lift. CNA B stated she received training twice a year. CNA B stated she did not see if CNA A had secured the brakes during the transfer. CNA B stated the brakes were required to be engaged when lifting and lowering the bed. CNA B stated risks included the potential for the mechanical lift to move during transfers, which could result in injury to the resident or staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/14/25 at 2:14 pm, CNA A stated she had received training on proper mechanical lift use, including how to hook the sling, ensure the sling is in good condition, and secure brakes during transfers. CNA A stated she forgot to secure the brakes during the lift and did not secure them when lowering the resident because the bed had been moved up. CNA A stated risks included potential injury to the resident or staff due to unsecured brakes.</p> <p>In an interview on 1/15/25 at 10:43 AM, with ADON C and ADON D, ADON C stated all nursing staff were trained on mechanical transfers and other transfers. ADON D stated they receive this training from the therapy department. ADON C stated when lifting a resident up from the bed or wheelchair the hoyer lift brakes have to be placed to lock. ADON D stated this was to secure and anchor the hoyer lift. ADON C stated the risk would be that the hoyer lift could move if it was not secure.</p> <p>Record review of the facility's Hydraulic Lift policy not dated read in part Goals: the resident will achieve safe transfer to bed or chair via mechanical lift device. The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift. Procedure: prepare the lift by setting the adjustable base to its position. Lock or unlock the base wheels according to the lift manufacture's recommendations.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>43871</p> <p>Based on observation, interview, and record review, the facility failed to ensure they had a full time DON for 1 of 1 facility reviewed for DON coverage.</p> <p>The facility failed to have a full-time DON since 12/05/24 .</p> <p>This failure could place residents at risk of a lack of nursing oversight and a higher level of care.</p> <p>Findings included:</p> <p>Record review of staff hours from 12/01/24 through 01/15/25 indicated there was no DON in the facility from 12/06/24 through 01/15/25.</p> <p>In an interview on 01/14/25 at 8:40 AM, with the Administrator, ADON C, and ADON D, the Administrator stated the facility currently did not have a DON. ADON C stated the facility did not have an acting or interim DON. ADON D stated the facility was looking for a DON.</p> <p>In an interview on 01/15/25 at 10:53 AM, with ADON C and ADON D, ADON C stated they did not have a full time DON but were actively seeking to hire a DON. ADON D stated the facility was about to hire a DON but the applicant at the last minute turned down the offer. ADON C stated the facility was using social media and other websites to actively try to recruit a DON. ADON C stated the risk of not having a DON would be that there might be some tasks that would be out of the scope of what some nurse can and cannot which why the facility needed a DON. ADON D stated the facility needed to have that oversight of a manager a DON to be looking at everything.</p> <p>In an interview on 01/15/25 at 11:13 AM, with the Administrator, she stated the purpose of having a DON was so the DON could provide guidance to the nursing department. The Administrator stated the facility did have a corporate nurse and a weekend supervisor who was an RN that could provide that guidance. The Administrator stated the facility was using social media, websites, and by word of mouth to try to hire a DON.</p> <p>In an interview on 01/15/25 at 12:22 PM, with HR, he stated the facility did not have a full time DON nor an interim DON. HR stated they had an applicant that they were going to hire for DON but in the minute the applicant turned down the offer . HR stated the facility was using social media and websites to try to hire a full DON. HR stated the purpose of a DON was to manage all the nursing department, regulate all the services for the residents, and making sure the residents had all the services they needed. HR stated the risk was that services being provided to residents might not have oversight to ensure they were being provided. HR stated the last DON's last day in the facility was on 12/02/24 and official last day was on 12/05/24, since then, the facility has not had a full DON.</p> <p>In an interview on 01/15/25 at 12:32 PM, with the Administrator, she stated the facility did not have a DON policy and followed state guidelines.</p>		