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	06/20/2024

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

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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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to ensure that the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 5 of 18 residents (Resident #7, #8, #14, #51 and Resident #65) reviewed for activities of daily living., received reasonable accommodation of needs. The facility failed to place Residents #7, #8, #14 and #51's call lights within reach. The facility failed to ensure Resident #65's room door was closing properly. This deficient practice could affect all residents who need assistance with activities of daily living of not having needs met. Findings included: RESIDENT #7 Record review of Resident #7's face sheet dated 06/18/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #7's History and Physical dated 10/13/2023 revealed he had diagnoses including cerebral palsy and seizures. Record review of Resident #7's quarterly MDS dated [DATE] revealed he had a BIMS score of 14 (Cognitively intact). He had functional limitations in the range of motion of both his arms and legs. He was dependent on facility staff for toileting, bathing, upper and lower body dressing, and personal hygiene. He was dependent on facility staff to move around in bed, sit up in bed and lie back down. Record review of Resident #7's care plan revised 02/29/2024 revealed he had a potential for falls. Interventions included that items frequently used by the resident would be kept within easy reach. His call light was to be within reach and he was to be encouraged to use it for assistance as needed. Record review of Resident #7's care plan dated 10/15/2020 revealed he had a visual impairment and so was at risk for falls. Interventions included that his call light was to be kept within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/18/24 at 09:04 AM. Resident #7 was lying in bed. His call light was seen out of reach under the bed. He said he needed help transferring from the bed into the wheelchair. The resident said the call light was sometimes within reach but not all the time, so it was hard to get ahold of someone when he needed to get out of the bed. RESIDENT #8 Record review of Resident #8's admission record dated 06/19/2024 indicated she was admitted to the facility on [DATE] with diagnoses of muscle weakness, muscle wasting and atrophy. She was [AGE] years of age. Record review of Resident #8's MDS dated [DATE] indicated in part: BIMS = 10 indicating resident was moderately impaired. Mobility devices = Wheelchair. Bladder and bowel: Urinary/bowel continence = Frequently incontinent. Record review of Resident #8's care plan revised on 12/14/2023 revealed Focus: Falls: Goal: Resident will not sustain a fall related injury by utilizing fall precautions through next review date. Interventions: Anticipate and meet the resident's needs. Place items frequently used by the resident within easy reach when in the room. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. During an observation on 06/18/24 at 09:31 AM, the call light in resident rest room [ROOM NUMBER] did not have a cord for Resident #8 to pull so she could call for help. The call light switch only had a ring attached to it where the string used to be tied to therefore the resident would not be able to call for help in case she fell on the floor and would be unable to reach the call light switch. During an interview on 06/18/24 at 09:34 AM, Resident #8 whom used a wheelchair to get around the facility said she would use the rest room on her own and sometimes she would call for assistance by pulling on the ring of the call light switch. The resident said she was aware the string was missing because the other room she used to reside in had a string. The resident said she had not fallen in the restroom but if she did, she would not be able to call for help as she would not be able to reach the ring on the call light switch. RESIDENT #51 Record review of Resident #51's Face Sheet dated 06/18/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #51's History and Physical dated 07/11/2023 revealed he had a history of falls and had a concussion with loss of consciousness. Record review of Resident #51's annual MDS dated [DATE] revealed he had a BIMS score of 12 (Moderate cognitive impairment). He had limitations in his range of motion in one leg and both arms. He needed staff supervision or steadying by staff for toileting, upper body dressing, personal hygiene, and for transfers. He needed moderate assistance from staff for bathing and lower body dressing. He had fallen once since he was admitted to the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/18/24 at 09:04 AM, Resident #51's call light was attached to the privacy curtain and out of his reach. Resident #51 said he was able to transfer on his own and did not need help. He stated he did not clip the call light to the privacy curtain and that the CNA had put it there when they came in the morning. Resident #14 Record review of Resident #14 ' s electronic diagnoses listing accessed 11/07/2023 revealed diagnoses of history of falling, generalized muscle weakness, lack of coordination, difficulty walking, muscle wasting and atrophy, other reduced mobility, other intraarticular fracture of lower end of left radius. Record review of Resident #14 ' s annual MDS assessment dated [DATE] revealed a BIMS score of 04, her cognitive was severely impaired and required substantial/maximal assistance for fall prevention. Record review of Resident #14 ' s care plan revealed she had impaired visual function related to natural aging process and was at risk for falls, injury, and a decline in functional ability. It was revealed that staff were to anticipate her needs and meet them as able. It stated that the staff at the facility needed to keep a call light in reach when Resident #14 was in her room or bathroom. It stated that Resident #14 has a communication problem related to a history of infection causing impaired cognition, confusion secondary to impaired cognition, dementia. It said that staff needed to ensure and provide a safe environment with the call light in reach, adequate low glare light, bed in lowest position and wheels locked, and to avoid isolation. It stated that Resident #14 had been educated to use a call light for assistance. In an observation on 06/18/24 at 09:56 AM., Resident #14 was asleep on her bed. The call light was on the floor by the foot of the bed. In an observation and interview on 06/19/24 at 09:32 am, with Med Aide I revealed, Resident #14 was in bed and the call light was on the floor by the foot of the bed. Interview with Med Aide I revealed that she knew Resident #14 but did not provide direct care to the resident since she's an MA (medication aide). The surveyor pointed out the call light that was found on the floor and Med Aide I said that it should not be there because Resident #14 is on fall precautions and if she needs help, she would not be able to reach for it. Med Aide I picked up the call light from the floor and placed it on the resident's bed sheet near her reach. During observation and interview on 06/19/24 at 09:33 am, CNA A revealed that Resident #14 fell from her bed about 2 to 3 weeks ago but there were no major injuries upon assessment of the resident. Surveyor showed the pictures of the call light being on the floor the day before (06/18/24) and a picture from the current morning and CNA A said that it was not correct for it to be on the floor and that the risk would be that if Resident #14 needed assistance, she would not be able to reach for the call light and that if she was to fall and injure herself, she would not be able to call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/19/24 at 3:00 pm, with RNC F she said that she was aware that Resident #14 had fallen about a week ago and that the risk of her not having the fall mat beside her bed could result in her getting injured if she was to fall again from bed. RNC F said that by the call light not being accessible to her, if she was to fall, or required assistance, she would not be able to reach it. or if she needed help and decided to get up to get the call light, she could potentially fall and injure herself. Record review of Resident Rights policy dated 11/28/16 read in part The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. Safe environment- the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility did not have a policy on Call-lights. Resident #65 Record review of Resident #65's face sheet dated 06/19/24 revealed a [AGE] year-old female was admitted to facility on 02/01/24. Record review of Resident #65's history and physical dated 02/01/24 revealed diagnoses of Alzheimer's dementia, anxiety, and depression. Record review of Resident #65's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, her cognitive was intact. During observation and interview on 06/18/24 at 8:49 a.m., Resident #65 was seen struggling to close the door to get access to her closet behind the room door. Resident #65 was alert and oriented to person, place, and event. Resident #65 stated the door gets stuck and struggles to open and close and sometimes must wait to open/close due to the door making a lot of noise in attempts to not wake up her roommate. Resident #65 stated the door had been like that since her admission. During an interview on 06/19/24 at 1:31 p.m., CNA G stated Resident #65's room door had been getting stuck and both staff and residents struggle to open and close the door. CNA G stated the door had been like that for several months. CNA G stated she had not reported it to maintenance due to forgetting. CNA G stated risk for room door not opening/closing properly was risk for possible injury or getting hurt. During an interview on 06/19/24 at 1:54 p.m., LVN H stated Resident #65 door had been hard to open and close for several months now, even since before Resident #65 had been admitted . LVN H stated the door had been reported to maintenance several time back but could not remember how long ago. LVN H stated the door not closing/opening properly could cause some harm to the residents when they struggle to open it. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/20/24 at 1:32 p.m., the Administrator stated Resident #65 door had been fixed yesterday (06/19/24). The Administrator stated Maintenance had replaced some screws to the door. The Administrator stated it was expected for the Maintenance department to do daily if not weekly rounds to see if anything required repair. The Administrator stated with the new company change the facility had switched over to online Maintenance request with a QR code and had been struggling to get it to work. The Administrator stated that failure for room door to open/close was possible struggle to get in and out of room, stubbing her toe during the struggle of opening the door. During an interview on 06/20/24 at 4:37 p.m., the Maintenance Director stated he was notified of Resident #65's door yesterday (06/19/24) and was fixed the same day. The Maintenance Director stated he was not aware of the door not working for days and/or months. The Maintenance Director stated he was the one responsible for overseeing things being repaired. The Maintenance Director stated the facility had electronic Maintenance application where they can submit problems by using QR code and did not have access to his account and had not received training on how to use the application. The Maintenance Director stated risk included in case of emergency there could be delays on getting to the resident to provide help. During an interview on 06/20/24 at 11:32 AM, ADON E said it was expected for the call lights to be within the reach of the residents. The ADON said if the call lights were not within reach of the resident, then they would not be able to call for help when they needed it. The ADON said they would monitor to make sure the residents had their call lights within reach by conducting walking rounds known as champion rounds where each staff member had a hall assigned to them to monitor. During an interview on 06/20/24 at 11:56 AM, RNC F said it was expected for the call lights to be within reach. The RNC said they would monitor the call lights by conducting champion rounds and checking that the call lights were within reach. During an interview on 06/20/24 at 12:17 PM, the Administrator said it was expected for the call lights to be within reach of the residents. The Administrator said if the call lights were not within reach, then the residents would not be able to call for assistance. The Administrator said they would monitor the call lights by conducting champion rounds and checking that the call lights were within the resident's reach. During an interview on 06/19/24 at 09:14 AM, the Administrator said they had no policy for call lights. Record review of Resident Rights policy dated 11/28/16 read in part The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. Safe environment- the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43871

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review the facility failed to implement written policies that prohibit and prevent abuse for 1 of 7 Resident #8) residents reviewed for abuse. The facility failed to implement their abuse policy when they failed to immediately suspend the Driver after Resident #8 ' s allegation of mistreatment was reported. This failure could place residents at risk of potential continued mistreatment and abuse. Findings included: Record review of Resident #8 ' s face sheet dated 06/19/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] and she was her own responsible party. Record review of Resident #8 ' s history and physical dated 11/07/23 revealed diagnoses of diabetes mellitus type 2, kidney stones, chronic pain, restless leg syndrome, physical debility, and depression. Record review of Resident #8 ' s quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, indicating her cognitive was intact. Record review of Resident #8 ' s nursing progress note dated 06/18/24 written by LVN K revealed [Resident #8] left facility with activity department. Record review of Resident #8 ' s event note dated 06/19/24 revealed location of event was transportation van, cognition was oriented/ no problem and no pain. Description of event was [Resident #8] went out with activities on 06/18/24 to the park. Today [Resident #8] voicing that driver was too rough with her when transferring into van. Head to toe assessment performed. No bruising, discoloration or any injuries noted. No complaints of pain. The vital signs were: blood pressure was 142/82, temperature was 97.8 degrees, pulse was 90, respirations were 17 and blood glucose was 84. The Resident statement was [Resident #8] voiced driver was too rough with her while transferring to van. The NP and Resident #8 ' s family member was notified on 06/19/24. Other information not described above was [Resident #8] is own responsible party. She is alert and oriented x3, however confused at times. Family member called out of courtesy and informed of the situation. Family member voiced no concerns and stated she would talk with [Resident #8]. Record review of Resident #8 ' s other event nurses note dated 06/20/24 written by LVN L revealed follow up note no new bruising, no new discoloration or any injuries noted. [Resident #8] has no complains of pain. No changes that required physician notification. Record review of Resident #8 ' s other event nurses note dated 06/20/24 written by LVN M revealed follow up note no complaints of pain or discomfort. Head to toe assessment shows no injury or discoloration to the body. {Resident #8} has made no further comments about her trip to the park. No changes made that required physician notification. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Driver ' s timecard dated 06/19/24 revealed she clocked in for her shift at 3:58 am and clocked out at 1:15 pm. During an interview on 06/19/24 at 11:01 am, Resident #8 stated the Driver had been rough with her yesterday (06/18/24) when she had assisted her to the van. Resident #8 stated she had been rough while she was in the wheelchair and had caused her pain to her leg. Resident #8 stated she had not mentioned anything to any of the staff because she was waiting to talk to State Office Surveyors. Resident #8 stated she did not have any pain. Resident #8 was alert and oriented to person and event. Resident #8 did not appear in any distress while she recalled the alleged incident. During an interview on 06/20/24 at 8:22 am, a call was placed to Resident #8 ' s family member, a voicemail was left to return the call. No call was returned by date and time of exit. During an interview on 06/20/24 at 8:31 am, Resident #8 was in her bed resting. Resident #8 stated the people from administration, whose name she did not recall, had spoken to her yesterday regarding the incident. Resident #8 stated the nurse had assessed her shortly after but could not recall the time. Resident #8 stated she did not have any pain and she felt safe. During an interview on 06/20/24 at 8:34 am, the Receptionist stated the Driver would pick up and drop off residents in the front entrance. The Receptionist stated she was able to see the Driver pick up and drop off residents in the front door and had not seen the Driver be rough with any residents. The Receptionist stated she had not received complaints from any residents and/or family members regarding the care provided by the Driver. During an interview on 06/20/24 at 8:55 am, Activities Assistant the facility had scheduled an outing to the park on 06/18/24. The Activities assistant stated she had taken Resident #8 from her room to the lobby where the Driver then assisted her to the van. Activities Assistant she did not see anything unusual during their interaction. Activities Director stated Resident #8 had not mentioned the alleged incident to her and had not appeared any different during the outing. During an interview on 09/20/24 at 9:01 am, Resident #58 who was alert and oriented to person, place, time, and event, stated he had gone to the outing on 06/18/24 to the park. Resident #58 stated he did not see anything out of the ordinary. Resident #58 stated Resident #8 was assisted by the Driver to be sat on the third row and was to his right side. Resident #58 stated after the Driver had assisted everyone to their seats, she had gone to each resident checking their seatbelts to ensure they were properly secured, and Resident #8 had not voiced any concerns. Resident #58 stated Resident #8 appeared ok during the outing. Resident #58 stated he had not seen the Driver been rough with anyone in any of the outings that he had been a part of. During an interview on 06/20/24 at 1:53 pm, the Interim DON stated she had been notified by the Administrator of the allegation on 06/18/24 at around 11:30 am and had assisted her with following up with Resident #8. The Interim DON stated Resident #8 had mentioned the Driver had pushed her with her wheelchair in the front of the van. The Interim DON stated she did not voice any pain and no injuries were noted. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 2:11 pm, ADON J stated she had been notified by the Administrator of Resident #8 ' s voiced allegation regarding Driver being rough with her. ADON J stated she had called the Driver on 06/18/24 at 11:53 am to inquire about her whereabouts and asked her to go to DON ' s office as soon as she arrived. ADON J stated she did not give specific of details due to the Driver being on the road. ADON J stated the Driver had arrived between 5-10 minutes after the call was made. ADON J stated the Driver had denied the alleged incident and stated that Resident #8 had not voiced any pain during and post outing to her. ADON J stated she had asked the Driver to write a statement and gave her the form for her to fill out. AODN J stated she assumed the Driver had gone to a private area to fill out the statement form. ADON J stated a couple of minutes had passed and she went to follow up on the Driver statement and could not find her. ADON J stated she placed a call to the Driver at 12:43 pm and asked where she was with the statement. ADON J stated the Driver told her she had taken Resident #19 to his dialysis appointment and was already back in the premises. ADON J stated she had explained to the Driver she was not supposed to take anyone anywhere due to the allegation made. ADON J stated the Driver had misunderstood the instructions given and was worried about Resident #19 missing his appointment. ADON J stated the Driver completed her statement and then clocked out for the day. During an interview on 06/20/24 at 3:10 pm, Resident #19 was in his room and was alert and oriented to person, place, time, and event. Resident #19 stated the Driver had taken him to his dialysis appointment yesterday 06/19/24 and not been rough with him. Resident #19 stated the Driver had always been very kind and denied any concerns. Resident #19 stated he felt safe in the facility. During an interview on 06/20/24 at 3:15 pm, the Administrator stated she had been notified of Resident #8 ' s allegation regarding the Driver being rough with her, on 06/10/24 at around 11:15am -11:30 am. The Administrator stated she and the Interim DON had gone to follow up with Resident #8 where she was assessed, and no injuries were noted, and no pain was voiced. The Administrator stated she had delegated to ADON J to call the Driver to inquire about her whereabouts and ask her to come in to DON office. The Administrator expected ADON J to have ensured the Driver wrote her statement and had exited the facility. The Administrator stated the Driver was suspended pending investigation. The Administrator stated the Driver had misunderstood what was asked from her and was concerned about getting Resident #19 to his dialysis appointment. The Administrator stated the driver had placed Resident #19 at risk for possible continued mistreatment. The Administrator stated the facility followed up with Resident #19 and he had denied any concerns with interactions with the Driver. The Administrator stated since she had been working in the facility, she had not received complaints regarding the Drivers care provided during transportation. During an interview on 06/20/24 at 4:32 pm, the Driver stated she had taken a group of residents to a local park on 06/18/24 that included Resident #8. The driver denied the allegation and stated Resident #8 had been her normal self during transportation and post transportation. The Driver stated Resident #8 had not voiced any concerns and/or to her and did not act any differently with her. The driver stated she had been called by the ADON J to go to the office and was questioned about the alleged incident regarding being rough with Resident #8 and was asked to write a statement. The Driver stated the ADON J and Interim DON had asked her what transportation was pending for the rest of the day and she understood that they would find arrangements to pick Resident #19 up after dialysis. The Driver stated she was concerned about Resident #19 missing his dialysis appointment and opted to take him and write her statement after she got back. The Driver stated she got called again by ADON J when she was turning into the facility asking her about the written statement in which she was not supposed to take anyone anywhere after they had asked her to write the statement. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Abuse/Neglect policy dated 03/29/18 read in part The resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident ' s medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Section F subpart #4 read in part With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34486 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs identified in the comprehensive assessment for two (Resident #59 and Resident #61) of 23 residents reviewed for comprehensive resident-centered care plans. The facility failed to include care plans to address Resident #59's limited range of motion of his upper and lower extremities. The facility failed to include care plans to address Resident #61's limited range of motion of his upper and lower extremities. This failure put residents at increased risk of being unable to maintain their highest practicable physical well-being. Findings included: Resident #59 Record review of Resident #59's face sheet dated 06/19/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #59's Admission MDS dated [DATE] revealed he was not able to speak. His vision was severely impaired. The BIMS assessment for cognitive status was not conducted because he was unable to speak. He had functional limitations in his range of motion (limit in ability to move that interferes with ADLS or places the resident at risk of injury) to the upper and lower extremities (arms and legs). He was dependent on staff to dress and for personal hygiene. Toileting and bathing did not take place during the three days before the assessment was done. He was dependent on staff to move around in bed and to sit up in bed. He did not stand and was not transferred out of bed during the three days before the assessment. His diagnoses included traumatic brain dysfunction (severe injury to the brain), tracheostomy status (tube into the throat for breathing), gastrostomy status (tube into the stomach for nutrition), muscle wasting and atrophy, and other reduced mobility. Record review of Resident #59's care plan with a review date of 04/05/2024 revealed no care plan to address the residents limited range of motion. Review of his care plan for ADL Self Care Performance deficit dated 03/14/2024 described interventions to address his inability to perform activities of daily living but did not describe interventions to address his muscle wasting and atrophy, reduced mobility, or his limited range of motion. Record review of Resident #59's physician orders dated 03/04/2024 revealed he was to receive occupational therapy five times a week for 60 days to return to his prior level of functioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #59's physician orders dated 03/04/2024 revealed he was to receive physical therapy three times a week for 60 days for therapeutic exercises and activities, neuromuscular reeducation. Observation on 06/18/24 at 09:36 AM revealed that Resident #59 was lying in bed. He did not respond when asked to confirm his name or when he was asked how he was doing. His knees were bent so his heels were about 12 inches from his buttocks. Resident # 61 Record review of Resident #61's face sheet dated 06/19/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #61's History and Physical dated 03/22/2024 revealed he had a medical history including a right thalamic stroke (blood clot in the brain), a craniotomy (brain surgery), intraventricular hemorrhage (bleeding in the brain), a tracheotomy, a gastrostomy and was in a chronic vegetative state (brain injury in which a person shows no sign of awareness). Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed he was non-verbal. His hearing and vision were highly impaired. His cognitive status and mood could not be assessed. He had impaired range of motion to upper and lower extremities (arms and legs). He was totally dependent on facility staff for toileting, bathing, dressing, for personal hygiene and for movement in and out of bed. He received 151 minutes of occupational therapy in the seven days before the assessment. He had not received any physical therapy in the seven days prior to the assessment. Record review of Resident #61's care plan dated 04/22/2024 revealed he had an ADL self-care performance deficit. The goal was that the resident would improve his current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Interventions included that staff would provide assistance with these activities but did not describe interventions to address his impaired range of motion to upper and lower extremities. Record review of Resident #61's physician's order dated 03/25/2024 revealed he was to receive OT therapy five times a week for eight weeks to return to his prior level of functioning. Record review of Resident #61's physician's order dated 02/09/2024 revealed he was to receive PT therapy two times a week for eight weeks to address abnormalities of gait and mobility, and lack of coordination and to improve safety and functional independence. In observation on 06/18/24 at 02:40 PM Resident #61 was lying in bed. When asked to confirm his name and asked how he was doing he did not respond. His legs were at the knees and were about 10 inches from his buttocks. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at 01:06 PM the Director of Rehabilitation revealed that she did not know if therapy services would be in Resident #59 or Resident #61's care plans. She stated that Resident #59 was currently on a break from therapies and Resident #61 had recently been evaluated but was not currently receiving physical or occupational therapy. She explained that residents usually received occupational and physical therapy for a time, and then were given a break. She said residents would remain on a break until nursing indicated that there was a change in the resident's condition which would trigger reevaluation by therapists. Based on the therapist's reevaluation, it was possible that a resident would requalify for therapy. She said the facility did not have a Restorative program, so interventions such as passive range of motion were not provided to residents. She said CNAs were not doing passive range of motion. In an interview on 06/20/24 at 05:28 PM the Interim DON revealed that if Resident #59 or Resident #61 were receiving therapies this should be on their care plan. She said that interventions to address limitations to a resident's range of motion should be on their care plan. She said that if interventions to address limitations to range of motion were not on the care plan it increased the resident's risk for contractures, decreased mobility and muscle atrophy. Record review of the facility policy Comprehensive Care Planning (undated) revealed that the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs identified in the comprehensive assessment. The care plan would describe services to be furnished to attain or maintain the resident's highest practicable physical well-being. Care planning drives the type of care and service that a resident receives. Interventions are the specific care and services that will be implemented.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review the facility failed to ensure residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs) for 1 of 7 residents (Resident #26) reviewed for meal assistance. The facility failed to encourage Resident #26 often during her meal per her care plan. This failure could place residents that needed encouragement to eat to maintain ADL independence at risk of possible weight loss and avoid ADL decline. Findings included: Record review of Resident #26 ' s face sheet dated 06/19/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #26 ' s history and physical dated 05/20/24 revealed a diagnosis of Alzheimer's disease, anorexia, cognitive communication deficit, and unspecified dementia. Record review of Resident #26 ' s annual MDS assessment dated [DATE] revealed a BIMS score of 04, her cognitive was severely impaired and required supervision or touching assistance with eating. Record review of Resident #26 ' s care plan dated 04/22/24 revealed focus area for ADL self-care performance deficit Alzheimer ' s dementia, muscle weakness, lack of coordination secondary to Alzheimer ' s disease with interventions/tasks of eating: supervision set up; requires encouragement often. During an observation on 06/18/24 at 06/18/24 at 12:12 pm, CNA G assisted Resident #26 to the dining room and guided her to her seat. CNA G placed utensils within reach of Resident #26. During an observation on 06/18/24 at 06/18/24 at 12:22 pm, Resident #26 was moving her food around the plate, was pushing the food to one side of the plate and was drinking her fluids. During an observation on 06/18/24 at 12:26 pm, LVN H approached Resident #26 and asked her if she was done eating. Resident #6 had placed a napkin over her food. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/18/24 at 12:34 pm, CNA I picked up Resident #26 ' s plate. CNA I stated Resident #26 had refused to eat and removed her plate from her. No second choice was offered, and no encouragement was provided during the 24 minutes Resident #26 had her lunch plate. CNA I stated she was familiar with Resident #26 ' s care needed and stated she did not offer a second choice because she knew Resident #26 would refuse. CNA I stated she did not encouraged Resident #26 to eat but respected her right to refuse her food. LVN H stated he had approached Resident #26, and she did not want to eat. LVN H stated he respected her right to refuse her food. LVN H stated he was not sure how many times they were expected to approach and offer help to residents. LVN H stated a second choice should have been offered to Resident #26 and asked CNA I to offer her a second choice. CNA I approached Resident #26 and asked her if she wanted a sandwich, and she nodded no. CNA I and LVN H stated the risk of not providing encouragement and/or offering a second choice was a possible weight loss. During an interview on 06/19/24 at 11:19 am, Resident #26 ' s RP denied any concerns with care provided to resident, stating the facility appeared to be taking very good care of Resident #26. During an interview on 06/19/24 at 2:37 pm, Interim DON stated it was expected for CNAs to approach and offer assistance and/or cue residents to eat during their meal. Interim DON stated if a resident does not eat, staff should have different staff approach residents to see if they were more receptive with different staff offering/cueing. Interim DON stated it was expected for staff to offer a second choice or supplement shake if they saw a resident refuse a meal. Interim DON stated CNAs were provided with meal assistance training upon hire, annually and as needed. Interim DON stated the risk for not offering second choice and/or providing encouragement to eat was possible weight loss. During an interview on 06/20/24 at 1:32 pm, the Administrator stated it was expected for staff to encourage residents to eat at least 2-3 times during the meal. The Administrator stated CNAs were responsible for providing assistance and encouragement to eat. The Administrator stated the charge nurse was responsible for ensuring the CNAs were providing adequate meal assistance. The Administrator stated CNAs were trained for meal assistance upon hire, annually and as needed. The Administrator stated risks included weight loss and decline in ADL. Record review of Nursing Responsibilities at Meal Service policy dated 2012 read in part Nursing services will cooperate with Dietary Department to ensure that each resident is served according to regulations. The use of properly trained and supervised volunteers, family members, and other individuals can enhance the quality of life and quality of care for residents. Procedure: Nursing Service associates should follow these guidelines regarding meal service: 5- Adapt space and equipment to assist residents in maintaining independent functioning, dignity, well-being, and self-determination. 9- Offer substitute food of equal nutritive value to a resident if the resident refuses a menu item or eats less than 50% of the meal.

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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** 43871 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 of 7 residents (Resident #15) reviewed for nail care. The facility failed to trim Resident #15 ' s fingernails. This failure could place residents at risk of cross contamination and skin scratches that could result in infection. Findings include: Record review of Resident #15 ' s face sheet dated 06/19/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #15 ' s history and physical dated 08/02/23 revealed a diagnosis of anemia, type 2 diabetes mellitus, Alzheimer ' s dementia, and hypertensive heart disease. Record review of Resident #15 ' s annual MDS assessment dated [DATE] revealed a BIMS score of 04, his cognitive was severely impaired and required substantial/maximal assistance with hygiene. Record review of Resident #15 ' s care plan dated 04/16/24 revealed a focus area for ADL self-care performance deficit dementia with interventions of personal hygiene/oral care: extensive x1 staff assistance with personal hygiene and oral care. During observation and interview on 06/18/24 at 12:15 pm, Resident #15 was seen eating a churro (a type of fried dough from Spanish and Portuguese cuisine, made with choux pastry dough piped into hot oil with a piping bag and large closed star tip or similar shape) with his hands and his nails were long with brown like particles under his nails. LVN H stated Resident #15 ' s nails were long and had brown like particles under his fingernails and the risk was cross contamination due to him eating food with his hands. LVN H stated the CNAs were responsible for trimming the fingernails. LVN H stated he had not noticed Resident #15 ' s fingernails were long. LVN H assisted Resident #15 to a sink next to him and assisted him to wash his hands. During an interview on 06/19/24 at 1:31 pm, CNA G stated she was the CNA responsible for Resident #15. CNA G stated the CNAs were responsible for trimming fingernails on Sundays. CNA G stated she had not noticed Resident #15 ' s fingernails were long and dirty. CNA G stated she received training in nail trimming upon hire and as needed. CNA G stated risk for nit trimming fingernails were acquired infection and possible injury if they scratched themselves. Resident #15 was pleasantly confused and did not answer questions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/24 at 2:37 pm, the Interim DON stated the CNAs were responsible for providing and ensuring residents fingernails were trimmed. The Interim DON stated fingernail trimming was scheduled on Sundays. The Interim DON stated the charge nurses were responsible for ensuring the CNAs were trimming residents' fingernails during their daily rounds and/or assessments. The Interim DON stated risk included acquired infection and skin abrasion if they scratched themselves. The Interim DON stated the CNAs received grooming training upon hire, annually and as needed. During an interview on 06/20/24 at 1:32 pm, the Administrator stated that CNAs were responsible for trimming resident ' s grooming which included trimming of fingernails. The Administrator stated the charge nurses were responsible of ensuring fingernails were trimmed by checking on their daily rounds. The Administrator stated it was expected for nails to be trimmed as needed. The Administrator risk for having long fingernails was residents could scratch themselves and was infection control. The Administrator stated CNAs were trained on ADLs care upon hire, annually and as needed. Record review of Nail Care policy dated 2003 read in part Nail management is the regular care of toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are usually done during the bath. Goals: 1- Nail care will be performed regularly and safely. 3- the resident will be free from infection.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review the facility failed to ensure all residents were provided, based on the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored activities and individual activities, designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident for 2 of 9 (Resident #65 and Resident #51) residents reviewed for activities. The facility failed to provide regular, individualized activities to Resident #65 and Resident #51. This failure placed residents at risk of decreased physical, mental, and psychosocial well-being. Findings included: Resident #51 Record review of Resident #51 ' s face sheet dated 06/18/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #51 ' s history and physical dated 07/11/23 revealed a diagnoseis of weakness, pain, history of falls, cerebral edema, and concussion with loss of consciousness of 30 minutes or less. Record review of Resident #51 ' s annual MDS assessment dated [DATE] revealed a BIMS score of 12, his cognitive was intact. Record review of Resident #51 ' s care plan dated 04/09/24 revealed a focus area for activities with interventions of provide the resident with materials for individual activities as desired. During an interview on 06/18/24 at 9:04 am, Resident #51 was in his room. Resident #51 stated he did not attend group activities due to his legs hurting and needed to take it easy. Resident #51 stated he preferred to stay in his room and the facility did not provide materials for activities to do in his room. Resident #65 Record review of Resident #65 ' s face sheet dated 06/19/24 revealed a [AGE] year-old female was admitted to facility on 02/01/24. Record review of Resident #65 ' s history and physical dated 02/01/24 revealed diagnoses of Alzheimer ' s dementia, anxiety, and depression. Record review of Resident #65 ' s quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, her cognitive was intact. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #65 ' s care plan dated 02/16/24 revealed focus area for activities with interventions/tasks of preferred activities: conversing with others, coloring, tell family stories. During observation and interview on 06/18/24 at 8:49 am, Resident #65 was in her room and was alert and oriented to person, place and event. Resident #65 stated she would be included in the group activities but did not have anything to do afterwards. Resident #65 stated when group activities were over, she did not have anything to do in her room. Resident #65 stated the TV in her room was on her roommate's side and she did not have one for herself. Resident #65 stated she had also been asked what she enjoyed doing and had mentioned she liked to color and had not been provided with materials to color. Resident #65 stated she would become very bored and would pace up and down the hallway to keep busy. During an interview on 06/19/24 at 1:31 pm, CNA G stated activities department were responsible for providing materials to residents for individualized leisure activities. CNA G stated activities staff would provide music and games daily and would visit for about 30 minutes. CNA G stated she had not seen Resident #65 with any materials to do activities in her room. During an interview on 06/19/24 at 1:54 pm, LVN H stated he had not seen materials provided to Resident #54 for room activities. LVN H stated activities were responsible for providing materials to do activities in the room. LVN H stated he had noticed Resident #65 pace up and down the hallway but she and never mentioned she didn't have anything to do and/or that she was bored. During an interview on 06/19/24 at 2:30 pm, Activities Assistant and Activities Director stated CNAs were responsible for providing materials for activities to do in room for the residents. Activities Assistant and Activities Director stated the CNAs could ask and had access to materials to provide to residents. Activities Assistant and Activities Director stated they had not received complaints regarding no materials being provided for in-room activities. Activities Assistant and Activities Director stated if residents did not receive materials that they enjoyed doing on their own, residents could become bored. During an interview on 06/19/24 at 2:37 pm, Interim DON stated activities department were responsible for providing materials to residents for leisure activities. Interim DON stated she had not received complaints regarding individualized in room activities. Interim DON stated the risk of not providing materials for leisure activities was being bored. During an interview on 06/20/24 at 1:32 pm, the Administrator stated the activities department were the ones responsible for providing materials for individualized leisure activities. The Administrator stated she had not received any complaints regarding in room activities. The Administrator stated the risk of not providing materials for in room activities included residents being isolated, lack of stimuli and possible depression. Record review of Individualized Activity Programs dated 2011 read in part The Activity Director and staff will provide individual programming to meet individual needs and interests. Section #2 revealed Individual programs are developed and implemented on a regular basis consistent with individualized leisure interests and based on assessment.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that residents did not receive psychotropic drugs on a PRN basis for more than 14 days for one (Resident #61) of three residents reviewed for PRN psychotropic medication orders exceeding 14 days. The facility failed to ensure that Resident #61 did not have a PRN order for Lorazepam (antianxiety medication) for more than 14 days. This failure could place residents at risk of side effects from receiving unnecessary psychotropic medications. Findings included: Record review of Resident #61's face sheet dated 06/19/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #61's Progress Note dated 02/07/2024 revealed he had a diagnosis of anxiety disorder. Record review of Resident #61's History and Physical dated 03/22/2024 revealed no diagnosis of anxiety disorder. Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed he was receiving antianxiety medication. A diagnosis of anxiety disorder was not indicated. Record review of Resident #61's care plan initiated 05/20/2024 revealed he used an anti-anxiety medication for anxiety disorder and would be free from discomfort or adverse reactions related to anti-anxiety therapy. Interventions included educating the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-anxiety medication, and monitoring and documenting side effects of the medication including drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, mania, hostility and rage, aggressive or impulsive behavior, or hallucinations. Record review of Resident #61's physician's order dated 03/23/2024 revealed he was to receive 2 MG of Lorazepam every 8 hours as needed for anxiety. The order was discontinued on 05/20/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #61's active physician's order dated 06/12/2024 indicated he was to receive Lorazepam (an anti-anxiety medication) every 8 hours as needed for anxiety. The order did not include a 14-day limit. The order indicated the medication was to treat the resident biting his lip. Record review of Resident #61's MAR for April 2024 revealed he received 2 MG of Lorazepam on 04/06/2024, 04/12/2024, and 04/21/2024. Record review of Resident #61's MAR for May 2024 revealed he received 2 MG of Lorazepam on 05/11/2024 and 05/14/2024. Record review of Resident #61's MAR for June 2024 (accessed on 06/19/2024) revealed he received 2 MG of Lorazepam on 06/12/2024 and 06/18/2024. In an interview on 06/20/24 at 02:47 PM, the interim DON revealed Resident #61 was getting Lorazepam as needed for biting his lip. She stated that the standard for PRN orders for psychotropic medications was that orders needed to specify a 14-day stop date. After 14 days the physician could reorder the medication. She said the stop date was the standard because if the medication was not needed it would be discontinued. She stated that if an order came in with a 14-day limit like Resident #61's order for Lorazepam, the nurse should ask the physician if he wanted to put a stop date. She said the 14-day stop date was necessary to prevent residents from receiving unnecessary medications which might have unwanted side effects. Record review of the facility policy Psychotropic Drugs revised 10/25/2017 revealed PRN orders for psychotropic drugs are limited to 14 days. If there is a reason the physician wants to extend an order beyond 14 days the reason for this should be documented in the medical record and indicate the duration of the PRN order.

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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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. The facility failed to keep refrigerator and dry storage free of moldy foods. The facility failed to keep the freezers clean. The facility failed to store food in sealed containers. The facility failed to keep one plastic container stored on a metal rack clean and free of dried food residues on its side. The facility failed to keep one plastic bag with 2 bottles of liquid caramel stored on a metal rack clean and free of food drippings. The caramel stored inside the bag had leaked to the floor. The facility failed to properly store cleaning chemicals. This failure could affect residents by placing them at risk of food borne illness. Findings include: Observation and interview with DM N on 06/18/2024 at 8:26 AM, revealed a pink stain of frozen liquid at the bottom of the freezer #2. DM N said that it looked like strawberry drippings and that the expectation was for all staff to make observations and to clean the refrigerators and freezers as needed. DM N said that the potential outcome of finding those drippings could result in cross contamination of food and for the residents to get sick. Dry Storage Room: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview with DM N on 06/18/24 8:28 AM, revealed there were 11 boxes stored on the floor of the dry Storage room that contained cleaning chemicals for the 3-compartment sink and detergent for the dishwasher. The DM N said that he had received these chemicals the day before on 6/17/2024 at around 4:00 PM. When asked about the potential risk of storing these chemicals inside the dry storage pantry, he stated that there could be a risk of chemical contamination if a chemical where to spill. DM N said that the chemicals are supposed to be stored separately in a shed outside the facility away from any food products, but that he had not been able to store them in the shed because he did not find the [NAME] to move the boxes. Observation of a metal rack at the side wall, there was a box, open and uncovered with dry pinto beans inside. DM N stated that it was not the correct way to store the beans and that the expectation was that if any dry food item is open, it needs to be placed inside a sealed container or a sealed bag. DM N said that the risk of not storing the beans inside a sealed container could result in cross contamination or the potential risk of pests getting inside. Observation to the metal rack located to the right of the dry storage room, revealed that at the bottom there was a plastic bag with 2 bottles inside of it that contained liquid caramel. A droplet of caramel was found on the floor beneath the rack where the bag with the caramel bottles was located. On the second level of the metal rack, a peanut butter container was found with food particles smeared on the exterior of the container with what appeared to be peanut butter and jelly. DM N said the risk of bottles with drippings or food particles is that they could attract pests and contaminate food. He said that the expectation was for staff to clean the condiment bottles after each use for safe storage. Policies and procedures for storing food in the dry storage room and for chemical storage were requested. Observation and interview with DM N on 06/18/24 at 8:30 AM, freezer #3 revealed a box with cucumbers and 2 boxes with onions. It was observed that the box containing cucumbers had 2 vegetables with mold on them. The 2 boxes with onions contained mushy and moldy onions inside. DM N said that he throws any food that is not fresh on Tuesdays. He said that he did not have records on how often these items are disposed of. He said that the risk of having moldy vegetables would result in contamination of the rest of the vegetables and possibly contaminate the food inside the refrigerator. DM N stated that he would be throwing away the moldy vegetables found inside the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On an interview with RNC F on 06/19/24 3:00 PM, she said all residents could be affected by storing moldy and spoiling food in the freezer. The surveyor showed the picture of the frost building up at the bottom of the freezer and RNC F said there was a risk of contamination from the drippings on the box and into the ice. She said the freezer and refrigerator must always be clean. On observation of the juice drippings, she stated there was a risk of cross contamination with the food stored in the freezer. RNC F observed the pictures from the chemical boxes stored directly on the floor of the dry storage room and said that they should not be on the floor and that they should not be in the kitchen or dry storage room. She said that there was a potential for contamination of the food of the residents if there was a chemical spill inside the room. The surveyor showed the picture of the box with pinto beans and RNC F stated that the expectation is to have them inside a container of a sealed container and that by storing them on an open box there was a potential for dust particles that could fall in or pests getting inside the box. Observation of the picture of the plastic container with dried food particles of peanut butter and jelly stored on the metal rack had the potential of attracting insects that could result in contamination and making residents sick. She said that the same thing could happen from the drippings on the floor from the bag that contained 2 bottles of caramel; stated that there was a risk of infection and that the drippings could potentially attract insects such as roaches and flies. The surveyor showed RNC F the pictures of the moldy vegetables that where inside the refrigerator and she said that there was a potential for them spoiling the rest of the food inside the refrigerator that could result on infection or making the residents sick if staff was to prepare food with them and for cross contamination. She said that those vegetables should not have been there and that they should be disposed of immediately. On an interview with Staff Q on 06/19/24 01:37 PM, revealed that by storing the spoiled and moldy vegetables that were found in the freezer #3 the potential outcome was that the food inside freezer #3 could spoil and could get the resident's sick. Saff Q was asked about the storage of the chemicals in the dry storage room and said that it is not the proper place to store the cleaning chemicals. She said there was a shed outside and the chemicals had to be stored there. She said that the potential outcome of storing the chemicals in the dry food storage room was that if there is a leak or spill of those chemicals, they could contaminate the food stored in the room. She said staff told her they had to store the chemicals in the dry storage room because they could not find the key for the shed to store the chemicals inside and that staff did not want to leave them outside, exposing them to the sun. Record review of the facility policy Food Storage and Supplies dated 2012 revealed that insecticides, sprays and cleaning supplies are stored separately from food products and disposable supplies. Record review of the facility policy Food Storage and Supplies dated 2012 revealed that dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled, best practice is that scoops should not be left in food containers or bins, but if so, handles should be upright and not contacting the food items. Containers are cleaned regularly. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Storeroom floors should be swept and mopped to be maintained in a sanitary manner to prevent vermin or pest infestation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of In-Service Training Attendance Roster dated 05/05/2024 addressed the instructions for daily, weekly and monthly cleaning schedules. Instructions are as follows: Dietary Service manager. This person is responsible for scheduling employees, supervising the department, and purchasing food and supplies. Consult with manager regarding the preparation of food items, tray assemble procedures, cleaning procedures, or any related questions. Inform the manager of any unusual situations. Spills are to be mopped up immediately. Use floor signs. Informing those in the area of the spill and then clean it up. Broken glass is to be swept up. DO NOT pick up broken glass with your bare hands. All stored items must be above the floor on surfaces which allow thorough cleaning. Nothing is to be placed or stored directly on the floor in the storeroom or refrigerator. The policies and procedures provided by the facility did not address the safe storage of food in the refrigerator to prevent food borne illness. Record review of Departmental In-service and meetings dated 6/18/2024-6/19/2024 addressed the following summary and objectives: Cleaning schedule is to be followed as posted depending on the position worked that day. Schedule is located in office on top of the schedule. The instructions provided did not address the sanitation or cleaning schedule for the refrigerator or the procedure to dispose of spoiled food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure the resident's medical records were complete and accurately documented in accordance with accepted professional standards and practices for 5 (Resident #1, #57, #59, #61 and #65) of 23 residents reviewed for advance directives. The facility failed to ensure that Resident #1, #57, #59, #61, and #65's Texas OOH DNR were completed correctly. This failure put residents at risk of not having their health care wishes honored, such as receiving unwanted resuscitative measures. Findings included: Resident #57 Record review of Resident #57's face sheet dated [DATE] revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #57's History and Physical dated [DATE] revealed he had diagnoses including severe traumatic brain injury, Tracheotomy status (tube into the neck for breathing), Gastrostomy status (tube into the stomach for nutrition), Encounter for palliative care (care focused on managing symptoms, not curing illness), impaired mobility and cognition, Record review of Resident #57's quarterly MDS assessment dated [DATE] revealed he was married, and non-verbal. He was rarely understood and rarely understood verbal content. He had severely impaired vision. His cognitive status and mood could not be assessed. He had impaired range of motion to upper and lower extremities (arms and legs). He was totally dependent on facility staff for toileting, bathing, dressing and for personal hygiene. Record review of Resident #57's care plan dated [DATE] revealed he had an order for Do Not Resuscitate, that his or his responsible party's decision for DNR would be honored. Interventions included that in the absence of blood pressure, pulse, or respiration, CPR would not be initiated. Record review of Resident #57's Texas OOH DNR dated [DATE] revealed his family member had signed in the space reserved for the resident's legal guardian, agent or proxy, rather than in the space reserved for a qualified relative. The family member's status as legal guardian, agent, or proxy was not indicated on the document. Record review of Resident #57's electronic medical record miscellaneous documents revealed no advance directives assigning his family member as legal guardian, agent, or proxy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 2:00 PM, the facility Social Worker revealed she educated families and residents about advance directives including out of hospital DNRs. She said when a DNR was enacted she would scan the document for inclusion in the resident's electronic file. She said she thought Resident #57's DNR may have been enacted in the hospital before the resident was admitted to the facility. She said she had not noticed that the family member's signature was in the area for the signature of the legal guardian, agent, or proxy and not in the space reserved for a qualified relative. She did not know if this affected the validity of the document. Resident #59 Record review of Resident #59's face sheet dated [DATE] revealed he was [AGE] years old and admitted to the facility on [DATE]. His diagnoses included unspecified intracranial injury with loss of consciousness status unknown (brain injury), Gastrostomy status, tracheostomy status. Record review of Resident #59's admission MDS assessment dated [DATE] revealed he was non-verbal. He had an impaired ability to hear and to understand others and was rarely understood. His ability to see was severely impaired. His cognitive status and mood could not be assessed. He had impaired range of motion to upper and lower extremities (arms and legs). He was totally dependent on facility staff for dressing and for personal hygiene. Record review of Resident #59's care plan dated [DATE] revealed he had an order for Do Not Resuscitate, that his or his responsible party's decision for DNR would be honored. Interventions included that in the absence of blood pressure, pulse, or respiration, CPR would not be initiated. Record review of Resident #59's Texas OOH DNR revealed there was no date on the document showing when it was enacted. The declaration by a qualified relative which was signed by a family member was not dated. Witness signatures were present but were not dated. Physician's signatures were present but were not dated. In an interview on [DATE] at 2:00 PM the facility Social Worker revealed she was present at the time Resident #59's DNR was enacted but did not know why it was not dated. She said the OOH DNR should be dated and did not know if it affected the validity of the document. She said this put the resident at risk of having CPR done which he did not want. Resident #61 Record review of Resident #61's face sheet dated [DATE] revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #61's History and Physical dated [DATE] revealed he had a medical history including a right thalamic stroke (blood clot in the brain), a craniotomy (brain surgery), intraventricular hemorrhage (bleeding in the brain), a tracheotomy, a gastrostomy and was in a chronic vegetative state (brain injury in which a person shows no sign of awareness). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed he was non-verbal. His hearing and vision were highly impaired. His cognitive status and mood could not be assessed. He had impaired range of motion to upper and lower extremities (arms and legs). He was totally dependent on facility staff for toileting, bathing, dressing, for personal hygiene and for movement in and out of bed. Record review of Resident #61's care plan revised [DATE] revealed that had an order for Do Not Resuscitate, that his or his responsible party's decision for DNR would be honored. Interventions included that should cardiac arrest (when the heart stops beating) occur or breathing independently cease, staff would allow a natural death. Record review of Resident #61's Texas OOH DNR dated [DATE] revealed his family member had signed in the space reserved for the resident's legal guardian, agent, or proxy, rather than in the space reserved for a qualified relative. The family member's status as legal guardian, agent, or proxy was not indicated on the document. Record review of Resident #61's electronic medical record miscellaneous documents revealed no advance directives assigning his family member as legal guardian, agent, or proxy. In an interview on [DATE] at 2:00 PM, the facility Social Worker revealed regarding the OOH DNR for Resident # 61, that the family member's signature was in the area for the legal guardian, agent, or proxy's signature and not in the space reserved for a qualified relative. She said she did not know why the signature of the family member was in the wrong place. She did not know if this affected the validity of the OOH DNR. Resident #65 Record review of Resident #65's face sheet dated [DATE] revealed a [AGE] year-old female was admitted to facility on [DATE] and was DNR status. Record review of Resident #65's history and physical dated [DATE] revealed diagnoses of Alzheimer's dementia, anxiety, and depression. Record review of Resident #65's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, her cognitive was intact. Record review of Resident #65's care plan dated [DATE] revealed a focus area for DNR: has physicians order that include an order for DNR with interventions of should cardiac arrest occur or breathing independently cease, staff will allow a natural death. Record review of Resident #65's physician order dated [DATE] revealed DNR. Record review of Resident #65's Texas OOH DNR dated [DATE] revealed her family member had signed and dated but failed to print their name in the space reserved for the resident's legal guardian, agent, or proxy, rather than in the space reserved for a qualified relative. The family member's status as legal guardian, agent, or proxy was not indicated on the document. Resident #65's date of birth was also missing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] and was DNR status. Record review of Resident #1's history and physical dated [DATE] revealed a diagnosis of anxiety, dementia, pulmonary hypertension, anorexia, and chronic idiopathic constipation. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 04, her cognitive was severely impaired. Record review of Resident #1's Texas OOH DNR dated [DATE] revealed her family member had signed in the space reserved for declaration of the adult person that was meant for a competent person to sign. The family member's status as legal guardian, agent, or proxy was not indicated on the document. In an interview on [DATE] at 02:33 PM, the Interim DON revealed that Social Services oversaw Advance Directives and would help families enact DNRs if desired. She stated that random audits were done periodically to ensure that DNRs were being enacted properly. She said that if a DNR was improperly enacted it could put the resident at risk of receiving CPR when they should not. Record review of the facility policy Do Not Resuscitate Order policy dated [DATE] read in part The facility will honor two types of Not Resuscitate orders: a physician's order for do not resuscitate and the Texas Out-of-Hospital DNR order. Out of hospital DNR form- the out of hospital DNR form was designed by the Texas Department of Human Services to comply with the requirements as set forth in the Health and Safety Code for the purpose of instructing Emergency Medical personnel and other health care professionals to forgo resuscitation attempts. The policy did not specify the proper way the form needed to be completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 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 to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #47 and #63) of 18 residents reviewed for infection control in that: The facility failed to ensure CNA A wiped from front to back during incontinent care of Resident #47. The facility failed to ensure Resident #63's oxygen nasal cannula was bagged when not in use. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: RESIDENT #47 Record review of Resident #47's admission record dated 06/19/2024 indicated she was admitted to the facility on [DATE] with diagnoses of heart failure, muscle wasting and atrophy. She was [AGE] years of age. Record review of Resident #47's MDS dated [DATE] revealed: BIMS = 13 indicating resident was cognitively intact. Bladder and bowel: Urinary/bowel continence = Always incontinent. Record review of Resident #47's care plan revised on 02/29/2024 revealed: Focus: Incontinence: Resident is incontinent of bowel/bladder related to Impaired mobility. Goal: The resident will be clean and odor free through next review date. Interventions: INCONTINENT: Check frequently for wetness and soiling and change as needed. During an observation on 06/19/24 at 09:12 AM, CNA B and CNA A performed incontinent care for Resident #47. CNA B performed incontinent care to the vaginal area and CNA A performed the care to the resident's rectal area. CNA A took some wet wipes and wiped from the resident's buttock down to the rectal area and the made contact with the resident's vaginal area as well. CNA A took more wipes and continued to wipe with a back to front motion while passing the wipe into the rectal area and then towards the vaginal area. During the wiping by CNA A it was noted that the wipes contained a smudge of bowel movement which was being wiped towards the resident's vaginal area. During an interview on 06/19/24 at 09:38 AM, CNA A said during incontinent care the correct way to wipe was to wipe in a motion from front to back. CNA A said she realized she had wiped from back to front when performing incontinent care for Resident #47. CNA A said she had gotten nervous and made that error. CNA A said if she wiped from back to front she could introduce germs from the rectal area into the vaginal area which could lead to a UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 11:30 AM, ADON E said it was expected for CNAs to wipe from front to back when they performed incontinent care. ADON E said if they wiped the wrong way it could lead to an infection. The ADON said she believed the failure occurred because the CNA got nervous. The ADON said they monitored the CNAs by conducting CNA competency checks on the staff's anniversary. During an interview on 06/20/24 at 11:58 AM, RNC F said it was expected for CNAs to wipe from front to back when performing incontinent care. RNC said if the CNA wiped in the opposite direction it could lead to infections such as UTIs. The RNC said the failure probably occurred because the CNA got nervous. The RNC said they would monitor the staff by conducting competency checks which were conducted on a random basis or annually. The RNC said they also conducted training and in-services on incontinent care and hand washing, the use of PPE and other infection control procedures. During an interview on 06/20/24 at 12:14 PM, the Administrator said it was expected for the CNAs to wipe from front to back during incontinent care to prevent infections. The Administrator said the failure occurred probably because the CNA got nervous. The Administrator said they would monitor their staff by conducting competency checks annually and as needed. RESIDENT #63 Record review of Resident #63's admission record dated 06/19/2024 indicated she was admitted to the facility on [DATE] with diagnosis of shortness of breath. She was [AGE] years of age. Record review of Resident #63's MDS dated [DATE] indicated in part: BIMS = 13 indicating resident was cognitively intact. Record review of Resident #63's care plan dated 01/30/2024 indicated in part: Focus: Oxygen -Resident uses oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. Goal: Resident will have no signs or symptoms of hypoxia through as needed and is at risk for ineffective gas exchange. Interventions: Administer oxygen therapy per physician's orders. Record review of Resident #63's order summary report indicated in part: Active orders as of 06/19/2024. Order summary: Change O2 (oxygen) tubing and humidifier bottle. every night shift every Sunday Ensure that tubing is dated when changed start date 02/11/24. During an observation on 06/18/24 at 09:38 AM, Resident #63's oxygen tubing was seen wrapped around the oxygen tank and the nasal canula resting on the wheelchair. Resident #63 said she had not removed the oxygen tubing herself that it was the staff that had removed it and left it in that position. During an interview on 06/19/24 at 03:48 PM, CNA B said Resident #63 would transfer herself out of her wheelchair into the bed and was not sure if she would remove the oxygen tube from herself. CNA B was made aware of the observation of the oxygen tube wrapped around the oxygen tank and the CNA said she did not know who might have done that. CNA B said when she removed a resident's oxygen tubing, she would store it in a plastic bag to prevent it from getting contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 11:35 AM, ADON E said it was expected for oxygen tubing and nasal cannulas to be stored in a plastic bag when not in use. The ADON said they were not supposed to be wrapped around the oxygen tank or just left out like on top of the dresser as this could contaminate the tube and nasal cannula which could lead to infections. The ADON said they would monitor to make sure the oxygen tubing and cannulas were stored in bags by conducting walking rounds know as champion rounds where each particular staff member had a hall assigned to them to monitor. During an interview on 06/20/24 at 11:59 AM, RNC F said it was expected for oxygen tubing and nasal cannulas to be stored in a bag. The RNC said if it was not stored it could lead to respiratory infections. The RNC said they monitored to make sure the tubing and nasal cannulas were stored correctly by conducting champion rounds which meant a particular staff member had a certain hall assigned to them and they would monitor that hall. The RNC believed the failure occurred due to staff not storing the tubes and nasal cannulas in the bags as they were supposed to. During an interview on 06/20/24 at 12:16 PM, RNC the Administrator said it was expected for oxygen tubing and nasal cannulas to be stored in a plastic bag when not in use. The Administrator said if the oxygen tubing and nasal cannulas were not stored it could lead to infections and cross contamination. The Administrator said they conducted rounds and spot checks to make sure the tubing and cannulas were stored correctly. Record review of the facility's policy titled Oxygen administration dated 02/13/2007 indicated in part: Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula face mask to treat hypoxemic (low blood oxygen) conditions caused by pulmonary or cardiac diseases. Goals: The resident will be free from infection. Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated. Record review of the facility's policy titled Perineal care dated 05/11/2022 indicated in part: It is essential that residents using various devices, absorbent products, external collection devices etc, be checked (and changed as needed) on a scheduled based upon the resident's voiding pattern, professional standards of practice and the manufacturer's recommendations. Purpose: This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infection and skin irritation and observing the resident's skin condition. Perform hand hygiene, DON gloves and all other PPE per standard precautions. Gently perform perineal care, wiping from clean, urethral area to dirty rectal area to avoid contaminating the urethral area - clean to dirty. Female resident: Working from front to back, wipe one side of the labia majora, the outside folds or perineal skin that protect the urinary meatus and the vaginal opening. Gently perform care to the buttocks and anal area working from front to back without contaminating the perineal area.

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	06/20/2024

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

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 49854 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for safe operating equipment in safe operating condition. -The facility failed to maintain the stove in operational condition. -The facility failed to maintain the freezer in operational condition. This failure could place residents at risk of foodborne illnesses; and potential for injury to residents and staff by not maintaining essential equipment in safe operating condition. Findings include: Observation and interview on 06/18/24 at 8:22 AM, with the DM N revealed that freezer #2 had condensation inside and that the bottom was frozen and had a thick layer of ice. In the ice, there were pieces of cardboard from the boxes stored at the bottom of the freezer and food particles that were stuck in the ice. DM N said he would place a work order with the maintenance department so they could repair the freezer The Surveyor asked DM N what was the procedure that he needed to follow to place a work order with the maintenance department and he explained that using his cell phone, he could take a picture of the QR code that was posted on the door of freezer #1; after scanning the QR code, an application would open in his cell phone which would allow him to report the issue to the maintenance department so that they could start working on repairing the freezer. DM N stated that it usually took about 24 hours for the maintenance department to take care of any issue reported through the application scanning the QR code. DMN stated that there was a potential of cross contamination by having ice buildup at the bottom of the freezer because food particles could get stuck in the ice. DM N scanned the QR code and reported the issue to the maintenance department and stated that he would provide the work order to the Surveyor. Observation and interview on 06/18/24 at 8:50 AM, with the DM N and [NAME] O revealed 4 of 8 stove knobs were missing. Both staff members stated that they had been working at the facility approximately for 2 months and that the stove knobs had been missing ever since they started working at the facility. DM N stated that he kept the stove knobs in his office and that whenever they were going to use the stove, he brought the knobs out to the kitchen so they could turn on the stove and regulate the temperature. He stated that he did this to prevent losing the stove knobs. DM N said he was struggling to find the knobs to replace the broken ones. The surveyor asked DM N what was the procedure that he needed to follow whenever he needed to replace an item for the kitchen, and he stated that he had been looking online for the parts to replace them. The surveyor asked DM N again for the procedure he needed to follow to order items for the kitchen, and DM N was not able to answer. The surveyor asked DMN N if he had informed the facility about the stove's condition or if he had documentation to demonstrate that he had requested for the stove to be fixed, and DM N said he did not have any documentation to demonstrate that. DM N stated that he had a quote with the total amount for the stove knobs. The surveyor requested the quote for the new stove knobs. (continued on next page)

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	06/20/2024

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

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 06/19/24 at 10:48 AM, the Maintenance Director P revealed that the procedure for maintenance to receive work orders to repair equipment at the facility was done through and application using the cell phone in which a QR code was scanned, and the application would describe the issue or equipment that needed to be repaired. The Maintenance Director stated that the QR code system was new and that it had been implemented for about a week. He said he did not have access to the application because his credentials were not working yet. The Maintenance Director stated that before the implementation of the phone application and the QR code system, there was a binder with a log at the nursing station that contained work orders for the maintenance department to follow up for repairs needed throughout the facility, but for the most part he was notified verbally about issues he needed to tend to. The interview revealed that he worked at the facility Monday to Friday from 8 am to 5 pm and that he believed he was told about the freezer on Friday before the survey. He said this was told to him verbally by the DM N. He said that he did not have records of this. The Maintenance Director stated that he usually writes things that need to be repaired on a note pad, but the issue with the freezer was not noted anywhere because he was informed about it when he was outside at the back of the facility and that he was not carrying a note pad with him. Regarding the stove in the kitchen, the Maintenance Director said that they had been missing for about a month or more. He said that he had previously requested the parts to fix the stove several times but that once he makes the order, it's out of his hands. He said that he had PDFs saved on his computer from when he requested these parts. The Surveyor requested the PDFs via email and email address was provided to the Maintenance Director. The requested PDF documents were not provided. In an interview on 06/19/24 at 01:37 PM, Staff Q revealed she started working at the facility about one month ago and that the QR system was already operational by the time she started. She stated that she was aware that the freezer was not functioning properly. Staff Q said that the potential outcome of the freezer having condensation and freezing on the bottom, could result in spoiling the food they store to cook for the residents at the facility. Staff Q said she was not aware of the missing knobs for the stove until the day before (06/18/24) and that the parts had been ordered so the maintenance department could fix the issue. She stated that the potential outcome of the stove not having the knobs is that the staff would not be able to properly regulate the flames to cook the food for the residents and there was potential of food borne illnesses. She said not having the stove in proper operational condition could result in injury to kitchen staff. In an interview on 06/19/24 at 03:00 PM, RNC F reveled by having ice buildup at the bottom of the freezer, there was a risk of contamination from the drippings on the box that was stuck into the ice and said that all freezers, freezer Record review of a work order placed on 6/18/2024 by Staff N revealed that it was requested for the maintenance department to fix the condensation of Freezer #2. It revealed on the comments section stating: Freezer is Condensating inside. Record review of an Order revealed that 6 Knobs cost $92.67. The Order did not have a date of when the parts had been ordered and it did not contain information stating that the parts were ordered. The surveyor asked Staff Q for clarification as to when the parts were ordered since there was no date on the document. Staff Q said she would find out about the purchase date but did not provide this information to the surveyor by the time of exit. Policies and Procedures for work orders, emails and quotes for repairing the stove were requested on 06/18/2024 but were not provided to the surveyor by the time of exit.