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	08/07/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed in that:-The facility failed on 8/4/25 to thaw two bags of boneless pork loin properly.-The facility failed on 8/4/25 to seal a receptacle containing refried beans in refrigerator #1.-The facility failed on 8/4/25 to seal Ziplock bags containing jalapenos and onions in refrigerator #1.-The facility failed on 8/4/25 to label an object approximately 15 inches long, wrapped in brown butcher paper and sealed in plastic wrap that was found inside refrigerator #2. -The facility failed on 8/4/25 to seal a receptacle containing cooked beef in refrigerator #2 and it was not used by the labeled use by date.-The facility failed on 8/5/25 to prevent cross-contamination while preparing puree diets.These failures could place residents who eat foods prepared in the kitchen at risk of cross contamination and food-borne illnesses.The findings include:During observation and interview on 8/4/25 at 8:07 AM with [NAME] D in the kitchen, two packs of boneless pork loin were observed inside a gray, square plastic receptacle in the kitchen sink, under the faucet. The faucet was closed, and the water was not running. [NAME] D stated that if the pork was to be used the same day, it had to be thawed under cold running water. He said leaving pork meat to thaw at room temperature was not acceptable and the procedure of leaving the meat to thaw under running cold water should not be stopped until it was prepared for cooking. [NAME] D explained that this protocol was essential because thawing pork could be susceptible to bacterial growth and infection, which could expose residents to cross-contaminated food. [NAME] D stated that if residents were to eat cross-contaminated food, they could become sick and experience severe stomach illness, vomiting, or diarrhea from bacterial pathogens which could lead to more serious health hazards including hospitalization. Under U.S. FDA Food Code 2022 Chapter 3-501.13 Thawing. Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (B) Completely submerged under running water: (1) At a water temperature of 21oC (degrees Celsius) (70oF) (degrees Fahrenheit) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF). The facility failed to follow this procedure and was in violation of this code. During observation and interview on 8/4/25 at 8:24 AM, an observation and interview with [NAME] D in the kitchen revealed several findings:-Refrigerator #1: A square, clear receptacle containing refried beans with a clear lid was not labeled and was not properly closed. The lid was slightly slid from the corner of the receptacle, creating an opening of about one inch. -At 8:26 AM, two clear Ziploc bags inside the same refrigerator, one containing jalapenos and the other onions, were found open and not sealed. Under U.S. FDA Food Code 2022 Chapter 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings. The facility was in violation of this code. Refrigerator #2:-An object approximately 15 inches long, wrapped in brown butcher paper and sealed in plastic wrap, was found unlabeled and undated inside the refrigerator. [NAME] D stated it was probably (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	leftover food from over the weekend. Under U.S. FDA Food Code 2022 Chapter 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. The facility was in violation of this code. Refrigerator #3:-A clear, square plastic receptacle with a green lid was labeled as Beef and had a prepared date of 7/17/25 with a use-by date of 7/23/25.Interview with [NAME] D: [NAME] D stated that all food items in the refrigerators needed to be properly closed, sealed, and labeled. He confirmed that Ziploc bags containing vegetables should have been closed to prevent cross-contamination. [NAME] D explained that using a cross-contaminated ingredient was potentially hazardous, and such items should have been disposed of immediately. [NAME] D reported that all cooks and the Director of Food and Nutrition were responsible for cleaning, organizing, and ensuring the contents of the refrigerators were properly sealed and labeled. He added that labels were used to provide use dates and identify contents that were not visible due to packaging. [NAME] D reported that this labeling system ensured food freshness, mitigated bacterial growth, and prevented cross-contamination. He confirmed that unlabeled food needed to be disposed of because cooks could not determine when it was received. [NAME] D also stated that if residents were to eat cross-contaminated food, they could become sick and experience symptoms like vomiting or diarrhea from bacterial pathogens, which could lead to serious illness and hospitalization. Under U.S. FDA Food Code 2022 Chapter 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings; The facility was in violation of this code.During an observation and interview on 8/5/2025 at 11:01 AM with [NAME] E, a demonstration of puree diets and mechanical chop diet were scheduled to be conducted with a surveyor present. During which time, [NAME] E placed 16 breaded chicken breasts and chicken stock into the blender. [NAME] E then proceeded to remove the lid to the blender with her bare hand and add more stock to improve consistency; it was observed [NAME] E placed the lid into the uncovered container where the cooked breaded chicken met the lid at 11:03 AM. She stated the blender lid was not allowed to be in the container with the cooked food due to concern for cross contamination. [NAME] E washed hands at the beginning of the puree demonstration, but failed to rewash her hands after cross contaminating the breaded chicken with the lid and her bare hand. [NAME] E reports gloves are not used as per facility's policy unless directly handling food with hands. Under U.S. FDA Food Code 2022 Chapter 3-301.11 paragraph B .FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment ., [NAME] E was not in compliance with the Food Code. [NAME] E had the equipment washed and sanitized by a dietary aide following the cross contamination, but failed to wash hands after touching the contaminated lid.In an interview conducted on 8/6/2025 at 01:32 PM, [NAME] E confirmed observations made on 8/5/2025 during puree demonstration where the blender lid was placed inside the container with the handle meeting cooked breaded chicken. [NAME] E reconfirmed this was cross contamination because the lid was handled by her bare hand with the potential outcome of feeding residents contaminated food. [NAME] E reported residents could become sick from their stomach if they were to eat contaminated food. [NAME] E was unable to elaborate on further outcomes or symptoms from sickness but agreed that some residents in the facility might have a compromised immune system, making them more susceptible to food borne illness. [NAME] E stated she was only required to use gloves when directly using her hands to prepare food and must practice hand hygiene before and after glove use. [NAME] E continued that it was the facility's policy that gloves do not have to be worn when using utensils as direct contact or serving food on the tray line.In an interview on 08/06/2025 at 1:32 PM with the Director of Food and Nutrition, he emphasized the critical importance of properly closing and sealing food items within the refrigerators to safeguard their composition and quality. He stated that if food was left unsealed or improperly closed, a range of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contaminants including mold and bacteria, could compromise the food, potentially rendering it spoiled and requiring it to be discarded. The Director of Food and Nutrition also highlighted the risk of cross-contamination, where an item could contaminate other food inside the refrigerator. Regarding meat, he clarified the correct thawing procedure: it had to be completely thawed inside the refrigerator or, if necessary, thawed under running water in the sink. The purpose of this was to ensure even thawing and prevent the dangerous growth of bacteria. Thawing meat at room temperature was explicitly deemed unacceptable, as this could lead to bacterial growth and, if consumed, could result in residents suffering from diarrhea, vomiting, or dehydration. He explained that if a cook prepared pureed food without gloves, and utensils touched both the cook's hands and the food, this was considered a serious breach of protocol that could lead to residents becoming sick. The Director of Food and Nutrition concluded by stressing that the firm expectation for all staff was to wear gloves when preparing food and handling cooking utensils to prevent such incidents of cross-contamination which could result in resident's becoming ill. In an interview on 8/7/25 at 5:00 PM with the Administrator, she stated that staff were expected to follow the facility's Policies and Procedures for kitchen and safety practices to prevent cross-contamination and food born illness. The Administrator said staff not wearing gloves and using utensils that had touched their bare hands could lead to cross-contamination and bacterial growth if those utensils touched the food. She explained that containers in the refrigerator not being properly sealed or closed posed a similar risk for growing bacteria and contaminating other food inside the refrigerators. The Administrator stated that thawing meat at room temperature was also a significant concern and said the proper procedure was to leave the meat thawing underneath the faucet with cold water running so that meat thawed evenly and to prevent growth of bacteria. The Administrator stressed that all these actions could potentially lead to cross-contamination and the growth of bacteria, which in turn could make residents ill with stomach infections that could result in them experiencing vomiting, diarrhea or dehydration. Record review of the facility's policies and procedures labeled Dietary Service Policy and Procedure manual revised on 4/9/25 stated in part: Infection Control, Frozen items are thawed in refrigeration or under cold running water in a draining sink. Record review of the facility's policies and procedures labeled Dietary Department Glove Standard Protocol, not dated, stated in part: Glove use will be minimized in favor of serving utensils. This preference is based on the FDA's [NAME] Paper, Interventions to Prevent or Minimize Risks Associated with Bare-Hand Contact with Ready-to-Eat Foods . The Guidance to Surveyors for F371 also states The appropriate use of utensils such as gloves, tongs, deli paper and spatulas is essential in preventing food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled. Failure to change gloves between tasks can contribute to cross-contamination. Proper hand washing techniques and glove use will be taught to all new hires to the dietary department during the orientation process. Their training will be verified with a hand washing and glove use proficiency audit . Gloves will not be worn on tray line. Instead, as much pre-assembly and/or prep work will be completed before meal service to minimize the potential for cross-contamination during service. If direct food contact is required to prepare a menu item, this preparation should be done prior to tray line while wearing a glove to perform this single task, and hands washed before and after glove use . Bare hand contact with tableware, glasses and eating utensils will also be minimized.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for one (Resident #9) of four resident reviewed for care plans.The facility failed to have a comprehensive person-centered care plan for Resident #9 to address the Resident's prescribed psychotropic medication, Mirtazapine 7.5 mg by mouth at bedtime.This failure could affect residents prescribed psychotropic medications by placing them at risk for not receiving care and services to meet their needs.Findings Include:Record review of Resident #9's face sheet dated 08/07/25 revealed an [AGE] year-old female with an admission date 06/09/21.Record review of Resident #9's health and physical dated 04/16/25 revealed resident's medical history, which were the following: Stroke (sudden interruption of continuous blood flow to the brain), Type 2 Diabetes (when the body cannot use insulin correctly and sugar builds up in the blood), Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and Deep Vein Thrombosis (a blood clot in a vein located deep within your body, usually in your leg).Record review of Resident #9's Quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status score of 0, indicating severe cognitive impairment. MDS revealed resident was taking an antidepressant.Record review of Resident #9's Order Summary Report dated 08/07/25 revealed resident was prescribed a psychotropic medication for appetite stimulation, Mirtazapine 7.5mg by mouth at bedtime, order start date 05/07/25.Record review of Resident #9's care plan dated 07/31/25 revealed her psychotropic medication, Mirtazapine, had not been cared planned. Interview on 08/07/25 at 3:29 PM with the Regional MDS Nurse revealed psychotropic medications were to be care planned. She stated psychotropics were to be added on the care plan so nursing staff could monitor residents for side effects relating to the psychotropic medications. She stated the risk to the resident was nursing staff being unable to identify the side effects and report as needed. The Regional MDS Nurse stated medications that were added to resident care was called an Acute Care Plan which was responsibility of the nursing staff.In an interview on 08/07/25 at 3:45 PM with the DON, she stated psychotropic medications were to be added to the residents' care plan. She stated care plans meant patient centered care, and it allows for staff to be aware of what medication side effects to monitor. She stated care plans also included non-pharmacological interventions that could benefit the residents. The DON stated, Acute Care Plans, and adding psychotropic medications to the care plan, were the responsibility of nursing staff and leadership. She stated the ADON's, and self (DON) were responsible for monitoring the care plans. She stated changes in resident care plans were discussed in daily morning rounding with the IDT team.During an interview on 08/07/25 at 4:14 PM with the ADON, she stated psychotropic medications were to be included in residents' care planned if prescribed. She stated care plans provided information about interventions and residents' specific health goals. The ADON stated nursing was responsible for reviewing care plans. She stated both ADON's and DON were responsible for monitoring residents' care plans on a quarterly basis. The ADON stated the risk of psychotropic medications not being in the care plan can affect the resident by not receiving the correct plan of care. She stated there was no reason psychotropic medication was not included in Resident #9's care plan. In an interview on 08/07/25 at 4:45 PM with the Administrator, she stated nursing was responsible for updated acute changes in the care plan and MDS nursing staff updated the Comprehensive Care Plan on a quarterly basis. She stated care plans reflected certain medications they were prescribed, and that information served as a guide on how to care for that resident. She stated risks of psychotropic medications not being included in residents' care plans would prevent staff on being aware of that resident's needs.Record Review of facility's policy and procedures, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Policy & Procedure Manual, labeled Comprehensive Care Planning with no date, read in part: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. It also stated, Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure biologicals were stored in locked compartments and accessed by authorized personnel for 1 (Resident #21) of 8 residents reviewed for medication storage, in that: Resident # 21 had two clear measuring cups at bedside, one with crushed medications and the second with a clear liquid, exposed and within reach of other residents. This failure could place residents at risk of access to medications not approved for administration by their physician. Findings included: Record Review of Resident # 21s' admission record dated 8/06/2025 revealed an [AGE] year-old female admitted to the facility on [DATE]. Record Review of Resident # 21's' history and physical dated 06/10/2025 revealed diagnoses of high blood pressure, other recurrent depressive disorder, constipation and rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood). Record Review of Resident # 21s' Quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating intact cognitive function. Record Review of Resident # 21's care plan revealed nursing interventions to include giving medications as per doctor's orders and to monitor for side effects of medication. Record review of Resident # 21's medication administration record dated 08/06/2025 revealed Resident #21's morning medications as Bupropion HCL oral tablet 75mg, Jardiance oral tablet 10mg, Losartan Potassium oral tablet 25 mg, Miralax Oral 17gm/scoop, Carvediol oral tablet 12.5mg, Docusate Sodium oral tablet 100mg, Lactulose oral solution 10gm/15ml and Simethicone oral tablet 80 mg. In an observation and interview on 08/04/25 at 10:15 am in Residents #21 room revealed, the room door open, two clear plastic measuring cups, one with crushed medications mixed with pudding and another cup with an unknown clear liquid on Resident #21's bedside table. Resident #21 did not know what the medications were. She stated that the nurse had left them for her to take after breakfast as she had requested. Resident #21's roommate was present in room as well. In an interview on 08/07/25 at 1:40 PM with LVN A, she stated that nurses and medication aids were to dispose of medications when residents did not want to take them. She stated that they were to never leave medication unattended for residents to take by themselves. She stated that when administering medications, nurses or medication aides were to stay with residents until residents finished taking medications to ensure that medication was ingested. She stated that leaving medications unattended could pose a risk to residents because it could easily be gotten a hold of, and the wrong resident could ingest the medication. She stated that whoever was administering the medication was responsible for ensuring medications were not left unattended or properly disposed of. In an interview on 08/07/2025 at 3:30pm with DON, revealed that medications were not to be left at bedside unattended for any resident. She stated that leaving medication unattended could potentially expose the resident to misuse of the medication such as medication being taken by another resident. She stated that it was also an infection control issue because it was exposed to air. She stated that it was the responsibility of the nurses to ensure that medications were not left at the bedside. In an interview on 08/07/25 at 4:30 PM with the Administrator, she stated that medications were not supposed to be left unattended at bedside. She stated that if a resident did not want to take medication at the time of administration, they were to dispose medications. She stated that leaving the medications at bedside could potentially expose other residents to getting a hold of the medications and accidentally taking them. She stated that it was the responsibility of either the nurse or medication aide to ensure that medications were being taken as per doctor's orders. She stated that she could not recall the last training/In service that was given over leaving medications at bedside. Record Review of facility policies and procedures titled Medication Administration and General Guidelines, not dated, reads in part Medications are administered at the time they are prepared. Medications are not pre-poured. The procedure reads observe the resident take the medications.