STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675568	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis Nursing & Rehabilitation Center	9001 N Loop El Paso, TX 79907

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observations, record review, and interviews, the facility failed to ensure that residents receive care, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #5) of 5 residents reviewed for quality of care. The facility failed on 03/29/2024 to ensure the pressure ulcer on Resident #5's right lateral foot was covered with a dressing as ordered. This failure could result in increased pain, infections, development of new pressure ulcers, and decline in quality of life for residents. Findings included: Review of Admission Record dated 03/29/24 at 12:39 PM, for Resident #5 revealed initial admitted d 11/02/2016 and re-admitted [DATE]. Record review of Annual History and Physical dated 07/20/2023 at 9:48 AM, for Resident #5 revealed [AGE] year-old male with past medical history of respiratory failure (a condition that makes it difficult to breathe on your own), vitamin D deficiency, hypertension, neuromuscular dysfunction (affect the function of muscles due to problems with the nerves and muscles in your body), benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and the bladder , blocking the flow of urine), retention of urine, paraplegia (paralysis that affects your legs, but not your arms), amputation of left leg above the knee, and GERD (gastroesophageal reflux disease). Resident has a suprapubic catheter (the placement of a drainage tube into the urinary bladder just above the pubic symphysis). He was oxygen dependent. He also had a history of behavior episodes. Baseline dementia. Plan: Turn every 2 hours while in bed. Wound care evaluates and treat. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Quarterly Minimum Data Set (MDS) dated [DATE], for Resident #5 clear speech; understood; understands; BIMS Score 13 cognitively intact; Behavior-verbal behavioral symptoms directed at others (e.g. , screaming at others, cursing at others) occurred 1 to 3 days; Rejection of Care-occurred 1 to 3 days; functional limitation of range of motion impairment on one side to lower extremity; wheelchair; Functional Ability: eating setup or clean-up assistance; oral hygiene partial/moderate assistance; toileting hygiene substantial/maximal assistance; shower substantial/maximal assistance; upper and lower body dressing substantial/maximal assistance; personal hygiene partial/moderate assistance; indwelling catheter; always incontinent of bowel; resident has a pressure ulcer; risk for development of pressure ulcer; 1 stage IV pressure ulcer; pressure reducing device for bed; antibiotic; Review of Care Plan revised on 01/19/2024, for Resident #5 revealed stage IV pressure ulcer right lateral foot. Revisions on: 01/08/2024. Interventions: Administer treatment as ordered and monitor for effectiveness. Replace loose or missing dressing PRN to right lateral foot stage IV pressure injury. Cleanse with wound cleanser, pat dry, apply TheraHoney gel (used on wounds to provide moist wound healing environment and helps rapidly reduce wound odor), cover with bordered island dressing, and change every M-W-F. Air mattress in place. Review of Physician Order Summary Report dated 03/29/24 at 12:39 PM, for Resident #5 revealed Consult with wound care physician to evaluate and treat wounds as needed. Stage IV pressure injury to the right lateral foot. Cleanse with wound cleanser, pat dry, apply TheraHoney gel, protect with bordered island dressing, and change every M-W-F. Wound care to evaluate and treat as warranted. Review of Medication Administration Record (MAR) dated March 2024, for Resident #5 revealed Stage IV pressure ulcer to right lateral foot: cleanse with wound cleanser, pat dry, apply TheraHoney gel, protect with bordered island dressing, and change every M-W-F. Record review of Wound Evaluation & Management Summary dated 03/25/24, for Resident #5 signed by wound care physician revealed Chief Complaint: Wound on his right lateral foot. Focused Wound Exam: Pressure Stage 4 0.2 x 0.2 x 0.1 cm. Plan of Care Reviewed and addressed: Dressing Treatment Plan: Leptosperum honey (Medihoney) apply three times per week for 23 days. Gauze island with border apply three times per week for 23 days. Observation 03/29/24 at 12:41 PM, with Wound Care Nurse A, revealed Resident #5 was lying in bed on his side. Resident was alert and oriented of person, place, and time. It was observed resident had an air mattress, sheets were clean, and dry. Resident #5 had an amputation of the left lower extremity above the knee, right lower extremity was constructed at the knee, and: stage IV pressure ulcer on the right lateral foot. It was observed Resident #5 did not have a wound dressing on right lateral foot. Wound Care Nurse A stated, Resident #5 should have a Bordered Island dressing on stage IV pressure ulcer on the right lateral foot as ordered by wound care physician. Wound Care Nurse B that works on the weekends is doing treatments today, and I do not know if the treatment has been done today . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/29/24 at 12:51 PM, the Wound Care Nurse A and LVN ADON C revealed Resident #5 had a stage IV pressure ulcer on right lateral foot and did not have a dressing on the wound. LVN ADON C stated, The weekend Wound Care Nurse B is doing treatments today and I will let her know that she needs to do the treatment on Resident #5's right lateral foot. The weekend Wound Care Nurse B is still in training, so she had not done the treatment yet for Resident #5. LVN ADON C and Wound Care Nurse A reported CNAs had been trained to immediately report to the charge nurses when the residents do not have the wound dressing in place to prevent injury to wound and/or infection. The Wound Care Nurse A stated, The CNAs usually are good about reporting this to the charge nurses. I will check and see if they reported this to his charge nurse . In an interview on 03/29/24 at 1:00 PM, Weekend Wound Care Nurse B reported she was covering for LVN Wound Care Nurse A today. She stated she was doing treatments and still had not done the treatment for Resident #5. Wound Care Nurse B stated, The CNAs have been trained to immediately report to the charge nurses when the residents do not have the dressings to the wounds to prevent injury and/or infection to the wound. In an interview on 03/29/24 at 1:12 PM, the DON reported CNAs had been trained to immediately report to the charge nurses when the residents do not have the dressings to the wounds, to prevent injury to wound and/or infection. The DON stated The ADONs just started re-training the staff today on immediately reporting to the nurses if the residents do not have the wound dressing in place to prevent injury and/or infection to the wound. In an interview on 03/29/24 at 1:12 PM, LVN Charge Nurse D reported CNAs had been trained to immediately report to the charge nurses when the residents did not have the dressings on the wounds, to prevent injury to wound and/or infection. In an interview on 04/01/24 at 12:59 PM, CNA E reported she had been assigned to Resident #5 on Friday March 29, 2024, on the 6:00 AM - 2:00 PM shift. CNA E stated Resident #5 has a pressure ulcer on the right lateral foot. On that day, I noted Resident #5 did not have the dressing on the pressure ulcer on the right outer foot. I was going to report it to the charge nurse, but I got busy with another resident and forgot to report it to the charge nurse. I re-checked Resident #5 at 7:00 AM but did not notice if the dressing was in place on the right lateral foot, because I did not lift the sheet to check the resident. Resident #5 did not allow me to check him for incontinence. It was just before lunch when I went to check Resident #5 for incontinence and that is when I noted the wound dressing to the right lateral foot was still not in place. We have been trained to immediately report to the charge nurses when the residents do not have the dressings to the wounds, to prevent injury to the wound and/or infection. In an interview on 04/01/24 at 3:01 PM, Medication Aide F revealed CNAs and Med Aides had been trained to immediately report to the charge nurses when the residents do not have the dressings to the wounds, to prevent injury and/or infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/02/24 at 12:14 PM, with Hospice CNA revealed Resident #5 had refused to shower on Thursday 03/28/24. Hospice CNA stated, I did not notice if Resident #5 had a wound dressing to the right lateral foot because he did not allow me to change his brief, so I did not pull the sheets down. Resident #5 became very angry when I attempted to pull the sheet down and started to cuss and yell at me. He kept asking me why I came every day to try to care for him. He stated, he could do whatever the Fuck he wanted. I reported the refusal of care to the LVN assigned to the resident. Record review of facility's policy on Pressure Injury: Prevention, Assessment and Treatment revised 08/12/16 revealed Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage as listed in this procedure. Notify physician; obtain an order and monitor site daily. Sign off on treatment sheet any treatment completed.

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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** 20026 Based on interviews and record review, the facility failed to maintain medical records that were complete and accurately documented for 5 (Resident #1, #2, #3, #4, and #5) of 5 residents reviewed for accurate medical records. 1. The facility failed to ensure LVN ADON C signed the Initial Skin Assessment when completed for Resident #1 on [DATE]. 2. The facility failed to ensure Social Worker signed and dated Care Plan Conference Form when completed for Resident #2 on [DATE]. 3. The facility failed to ensure Social Worker signed and dated Care Plan Conference Form when completed for Resident #3 on [DATE]. 4. The facility failed to ensure Social Worker signed and dated Care Plan Conference Form when completed for Resident #4 on [DATE]. 5. The facility failed to ensure Social Worker signed and dated Care Plan Conference Form when completed for Resident #5 on [DATE]. This failure could place residents at risk for misinformation about professional care provided. Findings included: Resident #1 Closed record review Admission Record dated [DATE] at 11:45 PM for Resident #1 revealed original admitted [DATE]. Resident #1 expired at nursing facility on [DATE] at 3:00 PM. Review of New Admission History and Physical dated [DATE] at 9:39 AM for Resident #1, revealed [AGE] year-old male with past medical history of hypertension, hyperlipidemia, coronary artery disease (a disease in which there is narrowing or blockage of the coronary artery) with history of Myocardial infarction (heart attack), diabetes mellitus type 2, GERD, BPH, obstructive sleep apnea, dementia, insomnia, hallucinations, anxiety, depression, bipolar disorder, acute respiratory failure (serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues) , pneumonia, metabolic encephalopathy (is a problem in the brain caused by chemical imbalance in the blood caused by an illness or organs that are not working as well as they should), stroke, rectal bleeding, and vertigo (is a sensation of motion or spinning that is often described as dizziness). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Admission Minimum Data Set (MDS) assessment (is a standardized assessment tool that measures health status in nursing home residents) dated [DATE] for Resident #1 revealed hearing adequate; clear speech ; understood; understands; vision adequate; BIMS Score 7 cognitively severely impaired; functional status - requires extensive assistance of two persons with bed mobility, transfer, and toilet use; extensive assistance of one person with locomotion on and off unit, dressing, and personal hygiene; supervision with eating; total assistance of one person with bathing; wheelchair; incontinent of bowel & bladder; Review of Care Plan for Resident #1 revealed, Resident is a diabetic initiated [DATE]. Resident required antipsychotic/antianxiety/antidepressant medication initiated [DATE]. Resident incontinent of bladder initiated [DATE]. Resident was on thickened liquids initiated [DATE]. Resident has a bruise initiated [DATE]. Impaired cognitive function r/t dementia. At risk for altered respiratory status r/t pneumonia. Self-Care deficit r/t muscle weakness. Undated Care Plan revealed resident #1 has stage IV pressure ulcer to coccyx. At risk for falls r/t poor safety awareness; resident is incontinent of bowel and bladder. Review of Care Plan Conference Form, for Resident #1 revealed Effective Date: [DATE] at 4:39 PM. Care Plan Conference Form was signed [DATE] by social worker. Review of Initial Skin Assessment Form dated [DATE] at 6:00 PM, for Resident #1 revealed form was not signed or dated. In an interview on [DATE] at 10:17 AM, with LVN ADON C revealed she had completed the Skin Assessment Form dated [DATE] at 6:00 PM, for Resident #1 and could not remember why she had not signed the assessment form. LVN ADON E stated she had been trained to sign the resident assessment form in the computer on the date that the assessment was completed . LVN ADON C reported DON and ADON are responsible for checking that assessment forms are signed and dated by licensed staff when assessments are completed to ensure electronic records are accurate, and complete. Resident #2 Review of Admission Record dated [DATE] at 12:31 PM for Resident #2 revealed original admitted [DATE] and re-admitted [DATE]. Review of New Admission History and Physical dated [DATE] at 9:11 AM, for Resident #2 revealed [AGE] year-old male with past medical history of BPH, chronic kidney disease, dysphagia (swallowing difficulties), diabetes mellitus type 2, UTI, atherosclerotic heart disease, hypertension, gastritis, moderate protein malnutrition, cardiac pacemaker, thrombocytopenia (a condition that occurs when the platelet count in the blood is too low) , Left heel wound, left foot amputation of 4th and 5th toes, and coccyx stage III. Review of Quarterly Minimum Data Set (MDS) dated [DATE], for Resident #2 revealed hearing adequate; clear speech; understood; understands; vision adequate; BIMS Score 9 cognitive moderately impaired; wheelchair; Functional Ability: eating partial/moderate assistance; oral hygiene partial/moderate assistance; toileting hygiene partial/moderate assistance; shower partial/moderate assistance ; upper body dressing supervision; lower body dressing partial/moderate assistance; personal hygiene partial/moderate assistance; roll left and right supervision; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of undated Care Plan for Resident #2 revealed Pacemaker r/t Atrial Fibrillation ; (an irregular heartbeat that occurs when the electrical signals in the atria (the two upper chambers of the heart) fire rapidly at the same time. This causes the heart to beat faster than normal.) Resident has hypertension; Resident has Diabetes Mellitus; Resident has renal failure r/t chronic kidney disease; Resident is on anticoagulant therapy; Resident has gastritis; Resident has diabetic ulcer right and left foot r/t diabetes; Self-Care deficit r/t muscle weakness. Record review Care Plan Conference Form for Resident #2 revealed effective Date: [DATE] at 11:53 AM. Care Plan Conference Form was signed [DATE] by social worker. Resident #3 Review of Admission Record dated [DATE] at 9:59 AM, for Resident #3 revealed original admitted [DATE] and readmitted on [DATE]. Record review of Annual History and Physical dated [DATE] at 9:22 AM, for Resident #3 revealed [AGE] year-old female with past medical history of anemia, cardiac arrest, diabetes mellitus type 2, hypertension, osteoarthritis , major depressive disorder, dementia w/o behaviors, vitamin D deficiency, vitamin B 12 deficiency, dysphagia , constipation, hyperlipidemia, osteoporosis (a bone disease that develops when bone material density and bone mass decreases, or when the structure and strength of bone changes.), and abnormalities with gait and mobility. Record review of Resident #3's Reentry Minimum Data Set (MDS) dated [DATE] revealed hearing adequate; clear speech; understood; usually understands; vision adequate; BIMS Score cognitive severely impaired; wheelchair; Functional Ability: eating supervision; oral hygiene partial/moderate assistance; toileting dependent; shower dependent; upper body dressing substantial/maximal assistance; lower body dressing dependent; personal hygiene substantial/maximal assistance; Record review of Care Plan for Resident #3 revealed Risk for skin impairment r/t incontinence revised on [DATE]; impaired decision-making r/t dementia revised [DATE]; risk for fall r/t unaware of safety needs, confusion, requires physical assistance with bed mobility and transfers revised [DATE]; able to self-proper in wheelchair revised [DATE]; impaired vision r/t cataracts revised [DATE]; communication problem r/t unclear speech revised [DATE]; Risk for altered mood problem r/t was found in male room in bed with male resident revised [DATE].; Record review Care Plan Conference Form for Resident #3 revealed effective Date: [DATE] at 11:53 AM. Care Plan Conference Form was signed [DATE] by social worker. Resident #4 Review of Admission Record dated [DATE] at 11:04 AM, for Resident #4 revealed original admitted [DATE]. Record review Annual History and Physical dated [DATE] at 9:07 AM, of Resident #4 revealed [AGE] year-old male with past medical history dementia without behavioral disturbances, diabetes mellitus type II, hypertension, Peripheral Vascular Disease (the reduced circulation of blood to a body part other than the brain or heart), chronic kidney disease stage III, osteoarthritis, major depression, BPH, vitamin D deficiency. Alert oriented X 1. He is pleasant and cooperative. (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 Quarterly Minimum Data Set (MDS) dated [DATE], for Resident #4 revealed hearing adequate; clear speech; understood; understands; vision adequate; BIMS Score 4 cognitive severely impaired; Functional Ability: eating independent; oral hygiene setup or clean-up assistance; toileting hygiene independent; shower supervision; upper and lower body dressing independent; personal hygiene independent. Record review of Care Plan for Resident #4 revealed Diabetes Mellitus revised on [DATE]. Resident has potential to demonstrate verbally abusive behaviors. He talks ugly to the employees and makes false accusations revised [DATE]. Record review Care Plan Conference Form for Resident #4 revealed effective Date: [DATE] at 10:10 AM. Care Plan Conference Form was signed [DATE] by social worker. Resident #5 Review of Admission Record dated [DATE] at 12:39 PM, for Resident #5 revealed original admitted [DATE] and readmitted [DATE]. Record review of Annual History and Physical dated [DATE] at 9:48 AM, for Resident #5 revealed [AGE] year-old male with past medical history of respiratory failure (a condition that makes it difficult to breather on your own), vitamin D deficiency, hypertension, neuromuscular dysfunction (affect the function of muscles due to problems with the nerves and muscles in your body), benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and the bladder , blocking the flow of urine), retention of urine, paraplegia (paralysis that affects your legs, but not your arms), amputation of left leg above the knee, GERD (gastroesophageal reflux disease). Resident has a suprapubic catheter (the placement of a drainage tube into the urinary bladder just above the pubic symphysis). He is oxygen dependent. He also has a history of behavior episodes. Baseline dementia. Plan: Turn every 2 hours while in bed. Wound care evaluates and treat. Review of Quarterly Minimum Data Set (MDS) dated [DATE], for Resident #5 revealed hearing adequate; clear speech; understood; understands; vision impaired; BIMS Score 13 cognitively intact; Behavior-verbal behavioral symptoms directed at others (e.g., screaming at others, cursing at others) occurred 1 to 3 days; Rejection of Care-occurred 1 to 3 days; functional limitation of range of motion impairment on one side to lower extremity; wheelchair; Functional Ability: eating setup or clean-up assistance; oral hygiene partial/moderate assistance; toileting hygiene substantial/maximal assistance; shower substantial/maximal assistance; upper and lower body dressing substantial/maximal assistance; personal hygiene partial/moderate assistance; Review of Care Plan for Resident #5 revealed has stage IV pressure ulcer right lateral foot revised on [DATE]. Interventions: administer treatment as ordered and monitor for effectiveness. Replace loose or missing dressing PRN to right lateral foot stage IV pressure injury. Cleanse with wound cleanser, pat dry, apply TheraHoney gel (is used on wounds to provide moist wound healing environment and helps rapidly reduce wound odor), cover with bordered island dressing and change every M-W-F. Air mattress in place. Record review of Care Plan Conference Form dated [DATE] for Resident #5 revealed Social Worker had had only provided the state surveyor page 1 of document on [DATE]. (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 and record review on [DATE] at 1:00 PM, with the DON revealed the Social Worker had not provided the state surveyor page 2 of the Care Plan Conference Form dated [DATE] for Resident #5. The DON provided the state surveyor page 2 of Care Plan Conference Form dated [DATE] for Resident #5. The DON confirmed the Care Plan Conference Form documented Effective Date: [DATE] at 11:39 AM and was signed by the Social Worker on [DATE]. The DON stated, I don't know why the form is dated [DATE], if the form was completed on [DATE]. Sometimes the staff will complete the forms and sign the forms later. The computer will stamp date the form when the form is signed. DON stated the staff should sign the electronic forms on the date that the forms are completed . DON reported that she and the ADON were responsible for checking that all documents in the clinical electronic records were signed by the staff on the date that the forms were completed to ensure records were accurate and complete. In an interview and record review on [DATE] at 1:20 PM, with the Social Worker confirmed she had completed the Care Plan Conference Form for Resident #5 on [DATE] and had signed the form on [DATE]. The Social Worker reported that she sometimes signs the forms later. The Social Worker stated that she was not aware if there was a facility policy that stated forms completed in the resident's electronic medical record needed to be signed on the date that the forms were completed . Review of facility policy on Documentation revised [DATE], provided by DON revealed, Documentation was the recording of all information, both objective and subjective, in the clinical record of an individual resident. It has legal requirements regarding accuracy and completeness, legibility, and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medications sheets, incident reports, and summary sheet (daily, weekly, monthly, discharge.) Documentation also occurs in the electronic clinical software. Goal: 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. Procedure: Place all required and appropriate signed forms in the clinical record. Document completed assessments in a timely manner and per policy. Each entry will be dated and timed. Each entry will be signed with proper signature and title. If electronic clinical record is used for the assessment the signature and title of the person entering the information will be signed by entering their password. In computerized documentation is used, safeguards and controls to protect the data from changes should be present; each authorized person must have a personal identifier and electronic signature based on qualifications to access and enter data.