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	04/18/2025

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 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** 49854 Based on observation, interview, and record review the facility failed to ensure residents receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Resident #52 and Resident #88) of 9 residents reviewed for call light placement. The facility failed to ensure call lights were at reach for Residents #52 and #88. This failure could affect residents by not having access to call for assistance resulting in needs not being met. Findings included: Resident #58 Review of Resident #52's face sheet dated 04/17/2025 reflected an [AGE] year-old female with an admitted [DATE] and a re-admitted [DATE] with diagnoses of a fracture of unspecified part of the neck of right femur, pain on right hip, muscle wasting and atrophy, difficulty in walking, unsteadiness on feet, muscle weakness generalized and other lack of coordination. Review of Resident #52's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 indicating a moderate cognitive impairment. Review of Resident #52's Functional Abilities revealed she had limitation in range of motion in upper and lower extremities. It revealed Resident #52 required substantial to maximal assistance with upper body dressing, sit to lying position, sit to stand, chair to bed transfer, toilet transfer and shower transfer. She was dependent for toileting hygiene, shower, lower body dressing and for putting and taking off footwear. Review of Resident #52's Comprehensive Care Plan revised on 11/13/2024 reflected that Resident #52 was at fall risk due to a personal history of falls and a hip fracture related to a fall. The plan called for intervention to anticipate and meet the needs of the resident, ensuring the call light was within reach and for staff to respond promptly to all requests for assistance. In an observation and interview on 04/15/25 at 11:01 AM, Resident #52 was lying in bed watching TV. Her call light was clipped to her bed sheet towards her right side, hanging behind in between the mattress and the headboard and out of her reach of the Resident. When asked if she could reach the call light, she said no. When asked what she would do if she needed help and couldn't reach it, she stated she did not know and would probably wait for a staff member to check on her in her room. (continued on next page)

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

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	04/18/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #88 Review of Resident #88's face sheet dated 04/16/2025 reflected a [AGE] year-old female with an admitted [DATE] with diagnoses of non-pressure chronic ulcer of back with unspecified severity, pain in unspecified joint, contracture of muscles in multiple sites, muscle wasting and atrophy, unspecified lack of coordination, muscle weakness generalized, unsteadiness on feet and lack of coordination. Review of Resident #88's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 indicating a moderate cognitive impairment. Review of Resident #88's Functional Abilities revealed she had limitation in range of motion in upper and lower extremities. It revealed Resident #88 required substantial to maximal assistance with eating, oral hygiene, upper body dressing and personal hygiene and she was dependent for toileting hygiene, shower, lower body dressing and for putting and taking off footwear. Review of Resident #88's Comprehensive Care Plan revised on 01/02/2025 reflected that Resident #88 was at risk of falls related to Cerebrovascular Accident (medical term for a stroke that occurs when the blood supply to part of the brain sin interrupted depriving brain tissue of oxygen) and required assistance with transfers and bed mobility. The Care Plan stated staff needed to ensure the residents' call light was within reach and to encourage the resident to use it for assistance as needed. In an observation on 04/16/25 at 10:43 AM Resident # 88 voiced to the surveyor that she was in pain, had a bowel movement, felt a burning sensation, and needed assistance from staff. The cable of her call light was located to her left side, clipped to her bed sheet towards the headboard, and the call light was lying between the mattress and the bed rail, out of her reach. Resident #88 stated she had not been able to call for help because she couldn't reach her call light and never knew where it was. The LVN was contacted to assist the resident. In an interview on 04/16/25 at 11:08 AM with CNA A she stated staff went to Resident's to rooms with the call light on to assist and consistently made rounds to ask residents if they needed something. She stated the call lights needed to be within reach of a resident so they could receive assistance, and if a resident couldn't use their call light, their condition could worsen, and they could get desperate. CNA A reviewed the pictures taken at Resident #55 and Resident #88 rooms and stated both call lights were not within the reach of the Residents. In an interview on 04/16/25 at 11:19 AM with LVN B reported that the call light was supposed to be within reach of residents. She noted that Resident #88's call light was not within reach when she went to assist her with a bowel movement, and the resident felt like it was burning. LVN B said rounds were made within 2 hours or as needed to ensure the Resident receive assistance in a timely manner. LVN B added that the risk for a resident not having their call lights within reach could result in them feeling distraught or ignored and if they had a fall and didn't receive assistance, their health could worsen by not receiving help in a timely manner. In an interview on 04/17/25 at 09:25 AM with the Social Worker she stated that call lights needed to be next to the residents and within reach. She mentioned a possible negative outcome of a resident not having a call light within reach could result in them not being assisted in time and could lead to worsening situations and their health. When the Social Worker was shown the pictures of Resident # 55 and Resident # 88 call lights, she agreed both call lights for the residents were not within reach. (continued on next page)

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	04/18/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/17/25 at 09:52 AM with the Corporate Nurse, she stated that call lights need to be always placed within reach of the residents. She stated that for both Resident # 55 and Resident # 88, the lights were not within reach. She added that staff needed to be making rounds to ensure call lights were within reach and that rounds should be done every two hours or as needed. She said that if a resident couldn't access a call light to request assistance, it could lead to health complications from the resident not being assisted on time. In an interview on 04/17/25 at 11:25 AM with the DON stated that call lights needed to be placed within reach of every resident so they could push the button to receive assistance. The DON noted that for residents who prefer the call light placed elsewhere, the preference needed to be care-planned. Regarding Resident #55 and Resident #88, DON stated the call lights were not within reach of the residents. The DON emphasized that not receiving care they needed in a timely manner and not being able to get assistance from staff were concerns and could possibly lead to health complications or, in the case of a resident fall, the potential negative outcome was they would not receive the assistance they needed in a timely manner. On 04/17/25 at 03:52 PM the DON entered the conference room and stated the facility did not have a specific policy addressing call lights.

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	04/18/2025

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 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** 51010 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date for one of three medications carts reviewed. - The high north hall nurse's cart had a smeared (illegible) dated insulin pen for Resident # 58 This failure could place residents at risk for harm by receiving ineffective insulin therapy. Finding included: Review of Resident 58's face sheet dated [DATE] revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. Review of Resident #58's medical diagnoses revealed Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema unspecified eye. Review of Resident #58's quarterly MDS assessment dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment. Review of Resident #58's Care Plan dated [DATE] revealed resident has Diabetes Mellitus and was at risk for hyper/hypoglycemia (high/low blood sugar). Record review of Resident #58's physician orders reflected the following order: NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject 3 unit subcutaneously three times a day for DM related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA. In an observation on [DATE] at 10:07 AM, while checking the north high side hall nurse's cart with LVN D, revealed a smeared (illegible) insulin pen date for Resident # 58. In an interview with LVN D on [DATE] at 10:07 AM revealed that all insulin pens were dated upon opening. She stated that the date was placed on the barrel of the pen, avoiding the plastic label portion of the pen because it could smear, preferably it should be dated on the paper label. In an interview with LVN E on [DATE] at 1:24 pm revealed that insulin pens should be dated as soon as they were opened for first use. Nurses were responsible to make sure that all pens were dated and to ensure that all dates were legible and not smeared off. A negative outcome for the resident would be using an old pen that was out of the range of the 28 days. (continued on next page)

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	04/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN B on [DATE] at 1:50 pm revealed that the insulin pens were dated as soon as they were opened, the date could be placed on the barrel but preferably on the paper tag to prevent smearing. She stated that all nurses were responsible to make sure all dates were printed clearly on the insulin pen. A negative outcome of an illegible date would be not knowing how long ago it was opened thus leading to medication being less effective. In an interview with the DON on [DATE] at 3:03 pm revealed that insulin pens were dated when opened, the date was placed on the label or on the barrel of the pen. She stated that the date was supposed to be placed on a spot where it would not smudge off. She stated that it was every nurse's responsibility to make sure pens were dated. A smudged off date could lead to medication being expired because it was unclear when it was opened, and medication could be less effective. Review of facility's policy titled Recommended Medication Storage revised in [DATE] revealed, Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened.

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	04/18/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51012 Based on observation, interview, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature, for one test tray reviewed. A test tray of the food served at lunch on 04/16/25 on hall revealed the ribs were not hot and at an appetizing temperature. This failure could place residents who ate in their rooms at-risk of poor intake and/or foodborne illness. The findings included: Observation of test tray provided to this surveyor on 04/16/25 at 12:32 PM, revealed temperature reading of lunch entree alternative ribs were 120F degrees. In an interview on 04/17/25 at 3:10 PM with Dietary [NAME] F revealed that hot food temperature readings should be 140F or 150F degrees at time of the resident is served. She stated the purpose for hot foods to be at that temperature was to satisfy the resident as they can become upset being served a cold meal when it was meant to be a warm meal. She stated the risks of hot food being below the required temperature included residents not eating their meals or harm such as illness. In an interview on 04/18/25 at 10:30 AM with the Director of Food and Nutrition revealed that food temperature when served to a resident should be 140F. She stated the food was to come out hot from the kitchen, but it does cool down when being transported in the cart to the resident. She stated the risks to residents of food being served below 140F degrees included the risk for infection or illness. She stated that all kitchen staff were responsible for ensuring food was served hot to the residents of the facility. In an interview on 04/18/25 at 12:45PM with CNA G revealed she was unsure of the required serving temperature per the facility policy, but stated it was to be hot, so the resident was encouraged to eat their meal. She stated the process of passing out meal trays included nurses confirming meal tickets with the tray and they wereare to be passed out to the resident. She stated lids wereare removed from trays when in front of the resident to maintain their temperature. She stated if meal entrees were lower than the required temperature per policy, the risk for the resident could include illness. CNA G stated the responsibility of serving hot food to residents included the CNA's as they helped serve the residents. CNA G stated the kitchen staff were responsible for monitoring meal trays maintaining the required temperature per policy. (continued on next page)

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	04/18/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/25 at 2:45PM with the DON revealed that all hot meal entrees were to be 140F degrees or above. She stated the kitchen staff were responsible to check the temperature of meal entrees at the steamtable and nursing staff were responsible to pass out trays in a timely manner. She stated supervisors or managers from different departments rotate on rounding on meal tray pass to make sure trays were passed out to residents in a timely manner. She stated that nurses were also responsible for ensuring CNA's pass out meal trays to residents in a timely manner. She stated the risk for the resident not being served meals of the required 140F degree temperature included resident dissatisfaction. The DON stated the Director of Food and Nutrition or the Kitchen Supervisor was responsible for monitoring meal temperatures to make sure they were the temperature required per their policy. Record review of the Facility's Dietary Services Policy and Procedure Manual titled Daily Food Temperature Control, dated 2012, revealed in part: We will assure that food is served at a safe temperature. All hot foods shall be cooked and held for service at temperatures of 140 degrees F or above.

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	04/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51012 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the kitchen. The facility failed to date 04/15/25 and label the contents of the disposable plastic cups that contained syrup located in the fridge in the facility's main kitchen. The facility failed to maintain corn dogs and red onions free from visible freezer burn. The facility failed to maintain the water temperature for 2 of 3 compartment sink per their policy. The facility failed to maintain the kitchen area free from staff personal belongings. The facility failed to cover and seal a meal cart containing the residents' meal trays while transporting them through zone/hallway # 6. These failures could place all residents who received meals from the main kitchen and place them at risk for food borne illness. The findings were: In an observation on 04/15/25 at 07:09 AM during the initial kitchen tour, the fridge located in the main kitchen had disposable plastic cups that contained syrup that was placed in a plastic bin and was sealed with plastic wrapping. The disposable plastic cups were not dated when prepared 04/15/25 or labeled with contents of the container. At 07:14 AM, corn dogs in a ziplock bag sealed and red onion in a plastic container, not sealed, placed in the freezer were observed with freezer burn. In an Observation on 04/15/2025 at 8:00 AM in zone # 6, CNA A was observed delivering meal trays for residents who ate breakfast in their rooms. The food cart containing the meal trays for the residents was observed to be left uncovered at 8:03 AM. Three of the plates in the meal cart were observed to not be properly covered and sealed with the heat-retaining lid. CNA A was observed rolling the uncovered meal cart down the hallway and covering the meal cart at 8:15 AM. CNA A was observed placing dirty meal trays with food leftover from other residents who had already finished their meals on the lower racks of the meal cart in near proximity to undelivered meal trays that were to be served to residents down the hall. CNA A moved the meal cart down the hall and uncovered the meal cart at 8:16 AM and it was left uncovered until the last tray was taken out of the cart and delivered at 8:35 AM. The cart rolled back to the kitchen at 8:38 AM. (continued on next page)

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	04/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Observation and Interview on 4/16/2025 at 08:15 AM with CNA C, she looked at the food cart and stated it was wrong to place soiled trays in close proximity to the trays with food that had not yet been delivered because there was a risk of cross-contamination. CNA C said the proper procedure was to place the soiled trays with the leftover food in the meal cart until all the food had been delivered to the rest of the residents in the hallway. CNA C said the possible outcome of leaving the cart uncovered for extended periods of time and placing soiled trays near other residents' food could result in cross-contamination potentially leading for residents to get sick, as well as the food for the residents getting cold. CNA C said if the food got cold, the resident might refuse to eat it, potentially leading to weight loss impacting the resident's health. In an observation on 04/17/25 at 10:00 AM, dietary cook used sink to wash kitchen utensils and this surveyor requested for temperature reading. Temperature readings for the Rinse compartment were 110F and the Wash compartment was 95F. In an interview on 04/16/25 at 10:55 AM CNA A stated she had been trained that all trays needed to be covered, and in between each delivery to every room, they needed to open and close the plastic from the carts. CNA A said she believed the bag served the purpose of insulating the cart to keep the resident's food warm and keeping the food free of cross-contamination. CNA A stated that leaving the cart uncovered could lead to cross-contamination and the food getting cold. CNA A said if the residents ate food that had been exposed to cross-contamination, there was a possibility for the residents to get sick. CNA A said she did not know what kind of sickness could result out of cross-contamination. CNA A said if the resident received cold food and refused to eat, she would ask if the resident wanted a substitution and offer it to the resident. CNA A said the potential outcome of a resident constantly refusing to eat a cold meal could result in poor satisfaction and create an uncomfortable environment for the resident In an Interview on 04/16/25 at 11:29 AM with LVN B, she said the cart should not have been left uncovered because there was a risk for infection control and also the food might not hold the correct temperature. LVN B said that if a resident ate a meal contaminated by cross-contamination, it might result in them getting sick or aggravating their condition. LVN B said delivering cold meals to residents could lead to them not feeling satisfied with the services they are provided by the facility. In an Interview on 04/16/25 at 2:26 PM with the Social Worker, she stated the plastic bag needed to be covering the cart all the way down to avoid leaving the resident's meals exposed to cross contamination. The Social Worker explained the reason for covering the cart with the bag all the way down was for infection control purposes. The Social Worker said the bag also served the purpose of keeping the food hot, and if it's left uncovered it could potentially make the resident decline their meal when they received it if it was cold, and if they request another meal, it creates delays on their times to eat, and if they were non-verbal and started refusing to eat, it could lead to weight loss and maybe sickness. The Social Worker stated that by leaving the meal cart uncovered, it could potentially result in cross-contamination and making the residents sick or worsening a pre-existing health condition. (continued on next page)

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	04/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview on 04/16/25 at 2:58 PM with the Corporate Nurse, she stated the plastic bag covering the meal carts was to keep the food retaining their temperature and for infection prevention control. She stated that the plates were covered and that should help retain the food temperature, and the bag acted as a second barrier to prevent infection and to have the food retain the heat. She stated that those plates that were not covered and sealed correctly with the heat retaining lid could potentially be contaminated and make the residents sick, and by not covering the cart with the plastic bag in between distribution, it could lead for the rest of the trays getting contaminated and the food not retaining their temperature. In an interview on 04/17/2025 at 11:18 AM with the DON said the purpose of the plastic bags were to keep the meal trays covered for infection control as a second protection and also to keep the food warm. The DON stated that the food in the meal cart was exposed because it was not properly covered by the heat retaining lids nor by the plastic cover. The DON said the potential outcome for not covering the meal carts could result in the residents receiving contaminated food and getting sick depending on what gets to the food. The DON noted the potential outcome for serving food that was cold for a resident was that they were not satisfied. In an interview on 04/17/25 at 3:14 PM with Dietary [NAME] F revealed the process of preparing individual packets included dating them. She stated kitchen staff were to date individual packages of food to ensure they were not to be used after expiration timeframe. She stated if any food items were not observed with a date, kitchen staff was to dispose of it as it was not confirmed when it was packaged or received by kitchen staff. She stated the risks of not dating food items in the kitchen included illness caused by bacteria. She stated all kitchen staff wereare responsible for ensuring all food items were dated and labeled. In an interview on 04/18/25 at 10:33 AM with the Director of Food and Nutrition revealed that the plastic seal on the container with individually packed syrups were to be labeled and dated. She stated the protocol for food preparation and packaging included for kitchen staff to date it after preparing it. She stated this was to prevent disposing of unlabeled food items. She stated all kitchen staff were responsible for monitoring food items that were labeled on a daily basis. She stated she was also responsible, and she reviewed food items every 13 days to confirm they were dated and labeled. She stated she did not there wasis not a lot of risk for the residents as the unlabeled food item was syrup. In an interview on 04/17/25 at 3:16 PM with Dietary [NAME] F revealed kitchen staff were responsible for confirming food in the freezer was sealed properly and dated. She stated the red onions in their original container were not sealed correctly and should have been placed in another plastic Ziplock bag. She stated the red onions, and the corn dogs had visible freezer burn and should be disposed of. She stated the purpose of sealed food items in the freezer was to prevent the food from hitting the air which can cause a risk for bacteria and illnesses for the residents. Dietary [NAME] G stated the Director of Food and Nutrition was responsible for monitoring all food items in the freezer are properly sealed. (continued on next page)

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	04/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/25 at 10:35 AM with the Director of Food and Nutrition revealed that the kitchen staff were to repackage food in a Ziplock bag as it cannot be resealed in its' original packaging. She stated the red onion and corn dogs were not to be used because of the visible freezer burn and was contaminated. She stated the risks for residents eating food with freezer burn or were not sealed properly can cause illness as it is contaminated by bacteria. She stated the residents could have possibly experienced diarrhea, or vomiting. She stated the responsibility was the kitchen staff and they were to monitor food items being properly sealed or not contaminated on a daily basis. In an interview on 04/17/25 at 3:18 PM with Dietary [NAME] F revealed that the water temperature of the three compartments sink varied depending on the compartment. She stated the purpose of the water temperature maintenance per their policy was to ensure the dishes were properly cleaned. She stated the risks for residents being served on dishes not properly washed or sanitized included cross contamination which could cause illness. She stated the responsibility belonged to all kitchen staff. In an interview on 04/18/25 at 10:40 AM with the Director of Food and Nutrition revealed the water temperature of the three-compartment sink should be hot or per the facility policy. She stated if temperatures were not per policy, the kitchen staff were to drain and fill it as necessary. She stated the kitchen staff using the sink at that time were responsible for confirming temperatures reflected per the facility policy. She stated the risks for residents of having lower water temperatures for the three-compartment sink included infections or illness, including symptoms such as diarrhea. She stated she was also responsible for confirming kitchen staff washing and sanitizing dishes per their policy. In an interview on 04/17/25 at 3:22 PM with Dietary [NAME] F revealed that there were no designated areas for personal belongings in the kitchen. She stated the water bottles, and the chocolate were in fact staff personal belongings, and they should not be there behind the mixer. She stated it was a cross-contamination issue as it was items coming from outside the facility. She stated the risk for the residents being served food from a kitchen with staff personal belongings including illness. She stated all kitchen staff were responsible for making sure the kitchen was free from staff personal belongings, and the Director of Food and Nutrition was responsible for monitoring that kitchen staff comply. In an interview on 04/18/25 at 10:49 AM with the Director of Food and Nutrition revealed there should not be any staff personal belongings in the kitchen. She stated personal belongings in the kitchen can pose a risk to residents by exposing them to outside items as it was a cross-contamination issue. She stated the risk of personal belongings in a kitchen was infection or illness for residents. In an interview on 04/18/25 at 02:50 PM with the DON revealed that their staff were not to have their personal belongings in the kitchen. The DON stated all personal items were to be kept out of the kitchen preparatory area because food was being handled to be served to the resident, and it posed as a risk for contamination. She stated possible risk included residents becoming ill. She stated that all kitchen staff were responsible for ensuring they placed their personal belongings outside of the kitchen preparation area. The DON stated the Director of Food and Nutrition was responsible for monitoring the kitchen for staff personal belongings. (continued on next page)

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	04/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facility's Dietary Policy and Procedure Manual titled Food Storage and Supplies, dated 2012, revealed in part: Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. These non-perishable foods are still dated when received if they do not have an expiration date and once opened, but do not need to be discarded within 7 days after opening. Perishable items that are refrigerated are dated once opened and used within 7 days. The policy did not address freezer burn on food items. Record Review of sign posted above the three-compartment sink labeled Three-Compartment Sink Procedures, no date, revealed in part: the Rinse Compartment Sink was to 120F +, and the Wash compartment sink was to be 110F +. Record review of the Facility's Dietary Policy and Procedure Manual titled Dietary Food Service Personnel Policy and Procedures, dated 2012, revealed in part: All personal belongings must be kept out of the food preparation area. Record Review of the Facility's Policy and Procedures Manual titled Nursing Responsibilities at Meal Service, dated 2012 stated in part: Trays will be passed in a timely manner. Food must remain covered while being distributed through the hallways. Pick up food trays from resident rooms and return them to the Dietary department. Soiled trays cannot be placed in food carts with undelivered trays. All food transferred to resident rooms will be covered. The eating surface of utensils will be covered.