STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	02/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on record review and interview, the facility failed to thoroughly investigate all alleged violations of resident abuse, neglect, exploitation, or mistreatment for 3 of 16 Facility Reported Incidents (#440095, #449979, #471822) reviewed for reporting allegations. The facility failed to thoroughly investigate: -An incident (#440095) when Resident #1 sustained a foot laceration during a shower and was not reported to nursing staff for at least two hours. -An incident (#449979) when Resident #4 complained of knee pain to which a right knee fracture was discovered at the hospital. -An incident (#471822) when an unoccupied shower room caught flame in the facility due to an electrical fire. This deficient practice placed residents at risk of abuse, neglect, exploitation, or mistreatment. The findings included: Record review of Resident #1's face sheet, dated 02/06/2024, reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of Nutritional Marasmus (a severe form of malnutrition). Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1's ability to shower was identified as total dependence requiring a single person assisting her. Resident has a BIMS score of 03 which indicated severe cognitive impairment. Record review of the TULIP intake #440095 reflected a self reported incident where Resident #1 was found with a cut to Resident #1's foot and went to the hospital after getting a shower earlier. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the incident investigation for #440095 soft folder prepared by the ADM reflected resident's face sheet (dated 07/28/2023), an Event Nurses' note (dated 07/28/2023), 8 resident witness statements, progress notes ranging from 07/28/23 to 07/30/2023 (printed on 08/03/2023), ED clinical summary (dated 08/03/2023), Facility in-service training (dated 07/28/2023) titled: abuse + neglect, safe resident handling, reporting, transfers. Facility completed in-service training with 15 of their 38 direct care staff. No evidence of staff statements was present in the soft folder. Record review of Resident #4's face sheet, dated 02/06/2024, reflected an [AGE] year-old originally admitted on [DATE] and a primary diagnosis of Dementia (A group of thinking and social symptoms that interferes with daily functioning). Record review of the TULIP intake #449979 reflected a self-reported incident where Resident #4 went to the hospital after stating Resident #4 had knee pain. The hospital found a break in Resident #4's knee. Record review of the incident investigation for intake #449979 soft folder prepared by the ADM reflected nursing notes (dated 09/07/2023), hospital discharge paperwork (dated 09/12/2023), and 9 witness statements from other residents. Facility completed in-service training with 13 of their 38 direct care staff. No evidence of staff statements or any other investigative components were present in the soft folder. Record review of the TULIP intake #471922 reflected a self-reported incident where one of the facility's shower rooms had an electrical fire while it was empty. Record review of the incident investigation for intake #471922 soft folder prepared by the ADM reflected invoices from two electricians and a general contractor, accompanied by a handwritten note that reflected 'smoke inhalation assessments were completed on all residents' and a risk assessment completed on 12/27/23 without any further details related to the smoke inhalation assessments or the risk assessment completed. No further self-reported incident investigation reports or tools were found associated with this intake. Attempted interview on 02/06/2024 at 2:24 PM with Resident #1, unable to be completed due to Resident #1 being non-interviewable. Interview on 02/06/2024 at 3:21 PM, the ADON stated the ADM completed the investigation (#440095) while she completed the in-service training on abuse, neglect, reporting and safe handling of the residents. The ADON stated the in-service was completed with the staff on shift the day of the incident. The ADON did not continue to train other staff because she felt the incident was an isolated incident caused by one singular staff member. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/08/2024 at 2:53 PM, the ADM stated no residents were in the shower room at the time of the fire. The ADM stated the fire was discovered in the morning and the invoices included in the soft folder were for the repairs made of plywood to the roof and the electrical connections. The ADM stated he originally felt his investigation of this incident was sufficient and thorough but only during state investigation did he see shortcomings in his process and evidence. The ADM stated investigations were a shared responsibility between himself and the DON or ADON when the DON was not available. The ADM stated it was his sole responsibility as it did not relate to nursing administration. The ADM stated he felt the risk associated with not completing a sufficient investigation involving facility fires would be that the incident could recur due to not determining the cause of the fire and whether residents were harmed as a result. The ADM stated the investigations for the other incidents were sufficient in his interpretation but only after reviewing them during the state investigation did he find unanswered questions. Record review of facility ANE policy, undated, reflected the ADM was the final responsible party for completing investigations of ANE or other reportable incidents in the facility and determining their sufficiency.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of three residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 received timely treatment and care that was eventually diagnosed with a laceration to the left foot. On 7/28/23, Resident #1 was found to have blood on her left foot when transferring to bed around 4 PM by NA AC. NA AD was aware of the injury prior to the end of her shift at 2 PM but did not report to a charge nurse. Resident #1 was left without care to her foot from the time NA AD noticed it bleeding (time undetermined) until 4 PM when NA AC noticed the foot bleeding. Resident #1 was sent to the hospital and was found to have a fracture of the fifth toe proximal phalanx. This deficient practice placed all residents at risk of experiencing a delay in treatment that could have resulted in harm or potentially death. The findings included: Record review of Resident #1's face sheet, 02/06/2024, reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of Nutritional Marasmus (a severe form of malnutrition) as well as a diagnosis of Cognitive Delays and Dementia. Resident is not intervenable due to her diagnosis of cognitive delays and dementia. Record review of Resident #1's quarterly MDS assessment, dated 06/28/2023, reflected Resident #1's ability to shower was identified as total dependence requiring a single person assisting her. Resident has a BIMS score of 03 which indicated severe cognitive impairment. Record review of Resident #1's care plan, dated 11/14/23, revealed Resident # 1 required assistance with ADLs including bathing, feeding, and transferring to and from bed/chair via 2-person lift. Resident required total care for showering, 1 person assist, and 2-person assistance with getting dressed. Record review of Resident #1's EHR reflected a shower record, dated 07/28/2023 recorded to have taken place at 1:59 PM by NA AD. Record review of Resident #1's eTransfer assessment form, dated 07/28/2023, reflected Resident #1 was transferred to the ER at 4:54 PM on 07/28/2023 due to [NA AC] noted blood to [Resident #1's] left foot 5th toe, upon assessment by writer laceration to back of 5th toe was noted with active bleeding. Record review of Resident #1's hospital record, dated 07/28/2023, reflected Resident #1 received an x-ray impression that read Mildly displaced fracture of the fifth toe proximal phalanx is age indeterminate . focal soft tissue defect at the lateral aspect of the fifth metatarsophalangeal joint (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the investigation soft folder for the incident, undated, prepared by the ADM reflected Resident #1's face sheet (dated 07/28/2023), an Event Nurses' note (dated 07/28/2023), 8 resident witness statements, progress notes ranging from 07/28/2023 to 07/30/2023 (printed on 08/03/2023), ED clinical summary (dated 08/03/2023), Facility in-service training (dated 07/28/2023) titled: abuse + neglect, safe resident handling, reporting, transfers. Facility completed in-service training with 15 of their 38 direct care staff. No evidence of staff statements or findings was present in the soft folder. Interview with LVN N at 3:35 PM revealed LVN N completed a head-to-toe skin assessment around 10 AM because the resident had a follow up telephone doctor's appointment for scabies. At the time of the head-to-toe assessment there was no noted injury to the resident's foot. Skin assessment did not reveal any scabies rash or injury to the resident's left foot. The bleeding on resident's left foot was reported to her by NA AC about 4 PM. LVN N determined the resident needed x-rays and sent the resident to the ER. LVN N worked a double shift (6AM to 10 PM) that day and was the charge nurse during the day shift also. LVN N stated the resident's injury was not identified during the day shift. It was not identified until the evening shift when NA AC noticed it during a transfer. When NA AC was asked about the injury, she stated that the injury was present prior to transferring the resident from wheelchair to bed. LVN N stated that NA AD was asked about the injury and stated that she noticed the injury prior to the end of her shift (2PM) but did not report it to anyone. LVN N stated that the resident was total care/ two person assist transfer. LVN N stated the facility completed in-service training on Abuse/Neglect/Exploitation, Reporting, Safe handling residents, and transferring on the same day as incident. Interview on 02/07/2024 at 11:04 AM, the ADON stated she became aware of Resident #1's bleeding foot once NA AC reported it to her at the start of NA AC's shift during rounding. The ADON stated during the investigation, she developed the theory that Resident #1's foot was injured during a shower with NA AD. The ADON stated the shower was done on the morning shift. The ADON stated her investigation revealed that NA AD was aware of the injury prior to the end of her shift at 2 PM but did not report to a charge nurse. When ADON interviewed NA AD it was revealed that NA AD noticed the resident's foot was bleeding prior to the end of her shift at 2 PM. NA AC took over for NA AD at 2 PM and noticed the resident's foot bleeding when resident was being transferred from her chair to her bed about 4 PM. The ADON stated during investigation, other CNAs reported to her that Resident #1 had a shower around 11:00 AM on 07/28/2023. The ADON stated her expectation was for the incident to have been reported by NA AD. Interview on 02/07/2024 at 3:35 PM, NA AC stated she observed Resident #1's pinky toe which appeared to be bleeding, to which the ADON and LVN N asked NA AC who worked before her, to which NA AC replied that NA AD was working before her. NA AC stated CNA AE also observed the bleeding. NA AC stated she saw a wound bandage without a signature, initials, or date on the patch where it was bleeding. CNA C stated NA AD was originally scheduled to work an additional shift on a different hall. NA AC stated following this incident, she participated in an in-service related to safe handling, reporting, and transfers. NA AC stated she did not work with NA AD after this incident. Attempted interview on 02/06/2024 at 2:24 PM with Resident #1. Unable to complete interview with Resident #1 being non-interviewable due to her diagnosis of cognitive delays and dementia. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Phone interview with NA AD was attempted on 02/06/2024 at 3:52 PM and 02/07/2024 at 9:15 AM with unsuccessful contact. Phone interview was attempted on 02/07/2024 at 3:46 PM with CNA AE with unsuccessful contact. Phone interview with Resident #1's Responsible Party was attempted on 02/06/2024 at 3:49 PM and 02/07/2024 at 9:20 AM with unsuccessful contact.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on record review and interview, the facility failed to provide an environment that is free from accident hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accidents to prevent accidents, for 1 of 19 residents (Resident #3) reviewed for accident hazards and supervision. Resident #3 fell to the ground during a mechanical lift transfer. This deficient practice placed residents at risk for accidents and injury. The findings included: Record review of Resident #3's admission record, dated 02/07/2024, reflected a [AGE] year-old with an admitted [DATE], and a primary diagnosis of cerebral infarction due to embolism of left middle cerebral artery (a stroke). Record review of Resident #3's MDS, dated [DATE], reflected Resident #3 was rated for bed transfer ability as totally dependent, requiring a two-person assist, and also reflected a BIMS of 0, indicating severe cognitive deficit. Record review of Resident #3's hospital records, dated 10/09/2023, reflected Resident #3 received six CT and XR scans that did not reveal injuries were sustained by the fall but admission to the hospital was reflected as head injury. Record review of an in-service, titled Hoyer Life Transfers-Safe Resident Handling, dated 10/9/23, reflected twelve total staff in attendance, with an additional page completed for same date with one additional staff in attendance that was also listed on the previous page. Record review of Witness Statements, dated 10/09/2023, reflected that CNA C stated Hoyer sling was placed incorrectly by [CNA AB]. [Resident #3] fell from hoyer when transferring from WC to bed and the second note by CNA AB, that stated I put to hoyer sling wrong. Record review of the TULIP intake #456415 reflected Resident #3 fell while staff were helping Resident #3 move from the bed using a large mechanical lift, and after it happened the staff that were there reported one of them made a mistake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/08/2024 at 10:19 AM, CNA C stated she was formerly known by a different name. CNA C stated she recalled the incident with Resident #3, and stated he needed a sling for the Hoyer transfer. CNA C stated she needed another staff to help her and asked CNA AB to help transfer Resident #3 to the shower. CNA C stated the two parts that needed to be around his head that connect to the hook were not placed right and after the machine was raised she noticed this as Resident #3 had fallen out of the Hoyer. CNA C stated it was not able to be fixed once he was in the air. CNA C stated Resident #3 did not have bleeding or exposed bone. CNA C stated after the incident, she left and got the ADON. CNA C stated she was interviewed by ADON following the incident to which the ADON asked her and CNA AB to document why the resident fell . Phone interview was attempted on 02/08/2024 at 10:13 AM with CNA AB with unsuccessful contact. Interview on 02/08/2024 at 11:01 AM, the ADON stated the incident involved Resident #3 was explained to her by CNA C and CNA AB as a mistake by CNA AB in placing the resident within the mechanical lift and causing him to fall and potentially hurt himself. The ADON stated it was her decision to transfer Resident #3 to the hospital to rule out a potential head injury but received Resident #3 following a lack of injury at the hospital. The ADON stated she recommended CNA AB be terminated but was not able to due to CNA AB not returning to work following the incident. The ADON stated she began in-servicing on mechanical lift transfers following this incident. Interview on 02/08/2024 at 11:29 AM, the ADM stated he was unfamiliar with the investigation related to Resident #3 and described it as a nursing function. The ADM stated he relied on the nursing administration such as the DON and ADON to complete the nursing investigation and recommend appropriate follow-up such as the in-service training and termination. The ADM stated it was his expectation that no resident be dropped by staff or subject to controllable accidents. A policy specific to accidents and hazards was requested on 02/09/2024 at 3:00 PM but was not provided to the investigation team prior to exit.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on observation, interview, and record review, the facility failed to ensure that all nursing staff have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 2 of 4 residents (Residents #1 and #3) reviewed for reportable incidents. The facility failed to complete in-service training to all direct care staff after four reportable incidents occurred involving Resident #1 and #3. Resident #1 had a fractured 5th toe. Resident #3 had a fall and hit his head after an improper mechanical transfer. This deficient practice could place residents at risk of being cared for by insufficiently trained staff following incidents that resulted in serious injury and risk of death. The findings included: Record review of Resident #1's face sheet, 02/06/2024 reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of Nutritional Marasmus (a severe form of malnutrition) as well as a diagnosis of Cognitive Delays and Dementia. Resident is not interviewable due to her diagnosis of cognitive delays and dementia. Record review of the incident report, undated, reflected Resident #1 was sent to the ER for x-rays on 07/28/2023 and diagnosed with a fracture in her 5th toe of her left foot. NA AD noticed Resident #1's foot was bleeding prior to the end of her shift at 2 pm. NA AC started her shift a 2 PM. When NA AC was assisting the resident with transferring from chair to bed NA AC noticed the blood on resident's left foot. NA AC reported the blood to LVN N and it was determined that Resident #1 needed x-rays. Resident #1 was sent to the ER where she was diagnosed with a fracture to her 5th toe on her left foot. Record review of the same incident report reflected staff in-service on 02/06/2024 titled Abuse/Neglect/Exploitation, Reporting, Safe handling residents, and transferring dated 07/28/2023 reflected 15 of 38 direct care staff were in-serviced. Alleged perpetrator did not receive this in-service training. Record review of an incident report, undated, reflected Resident #3 was sent to theER on [DATE] for a potential head injury after falling during an inadequate mechanical transfer. Record review of the same incident report staff in-service on 02/06/2024 titled Hoyer Life Transfers-Safe Resident Handling dated 10/09/2023 reflected 12 of 38 direct care staff were in-serviced. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/06/2024 at 4:05 P.M., the ADON stated she completed in-service training on Abuse/Neglect, reporting and safe handling/transferring residents on 07/28/2023 in response to the incident that happened on 07/28/2023 with Resident #1. The ADON stated she in-serviced staff that were present on the 2 P.M to 10 P.M. shift on 07/28/2023. The ADON stated she felt the need to in-service only the specific shift/staff and felt that it was an isolated incident caused by a particular staff member. The ADON stated she completed the in-services and followed her prescribed protocol of in-servicing only the immediately available staff at the time of the discovery of the incident. Interview on 02/09/2024 at 8:43 A.M., the ADM stated the facility staff are trained by corporate assignments in Relias and rely on the test/quiz to confirm the content apart from the regular in-services and onboarding staff receive. He stated there is no classroom setting where staff are required to do a return demonstration. The ADM stated investigation responsibilities are shared between himself, the DON, and the ADON in terms of their completion and implementation of changes made. The ADM stated he was the point of contact for the QA committee and the committee had each dept head complete individual audits of their respective departments and he relied on them to determine concerns. The ADM stated he was the final reviewer of the investigations and did not have concerns with the completion of the investigations until the state investigation began.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45307 Based on observation, interview, and record review, the facility failed to post the current nurse staffing data for 1 of 1 facility. The nurse staffing data on entrance on 02/06/2024 was for 01/29/2024. This deficient practice could place residents at risk by not providing adequate staffing information for the residents, staff, and visitors to ensure that resident care needs are met. The findings included: Observation on 02/06/2024 at 11:00 AM, revealed a posting detailing nurse staffing information for 01/29/2024 in front of the nurse's station. Interview on 02/06/2024 at 12:45 PM, the ADM stated the general postings within the facility were his responsibility. The ADM stated the nurse staffing data posting was a responsibility of the nursing department and deferred to the ADON for discussing the posting. Interview on 02/06/2024 at 3:45 PM, the ADON stated the nurse staffing data posting was her responsibility when the DON was not available in the facility. The ADON stated she was aware the posting was not updated and stated it was not updated because she had neglected to update it as she had forgotten. The ADON stated the last time it was updated was on 01/29/2024 and stated no one had made her aware of it until today. The ADON stated residents and visitors had access to the staff schedules at the nurses' station, but they must ask for the schedule book. The ADON stated she felt the risk associated with not keeping the nurse staffing data posting updated was that residents and visitors might not know the number of care staff present in the facility. Facility policy specific to postings or nurse staffing data was requested on 02/09/2024 at 3:00 PM to the ADM but was not given to the investigation team for review before exit.

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F 0837 Level of Harm - Potential for minimal harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 45307 Based on interview and record review, the facility failed to ensure that the facility has an active (engaged and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility for 1 of 1 facility. The governing body did not appoint an administrator who was actively engaged in establishing and implementing policies regarding the management of the facility by not involving himself in the investigations and in-servicing of staff following incidents occurring at the facility. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. The findings included: On 02/06/2024 at 11:25 AM, the investigation team conducted an entrance conference with the ADM. The ADM stated he was the current facility ADM and had received his LNFA within the last year and half. The ADM stated he was not familiar with all aspects of state licensure and compliance requirements. The ADM stated his role was to be a collaborative effort between himself and the department heads of the facility where he would defer to their expert judgement in making decisions related to their department. Interviews completed between 02/06/2024 at 11:00 a.m. and 02/10/2024 3:00 p.m., the ADM stated repeatedly he was unfamiliar with the specifics of the self-reported incidents that occurred at the facility and would rely on the respective department head to evaluate compliance; for example, the ADM stated incidents involving resident falls, choking incidents, or unwitnessed injuries were primarily reviewed by the nursing department and thus the DON and ADON would be chiefly responsible for determining the cause and proper response after the incidents. The ADM stated additionally he was not familiar with individual staff members as the nurse aides were in a perpetual state of leaving their positions and being hired on. The ADM stated also that he was not familiar with the medical director's expectations regarding in-servicing staff following a reportable incident such as a resident experiencing a major injury requiring hospitalization . Confidential interviews with direct care and administrative staff between 02/06/2024 at 11:00 a.m. and 02/10/2024 at 3:00 p.m. regarding the interaction and feedback the ADM had with the daily operation of the facility revealed staff identify the ADM to be the abuse coordinator however do not identify the ADM to be the primary responsible for receiving support in their respective department and rely on their department head to answer questions. Interviewees described previous administrators to be more interactive and hands-on in terms of their daily work and described the current ADM to often ask the respective department head for their own recommendations and only followed those recommendations. Several interviewees stated they would prefer more interaction and awareness of the daily operation of the facility by the ADM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	02/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

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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 0837 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of the ADM's personnel file reflected the ADM was hired on 08/09/2022 with an accompanied LNFA license expiring on 07/22/2024. Record review of the facility policy, titled Job Description - Administrator, dated 2014, reflected Accountable for total operation of the assigned nursing home in compliance with Standards of Operations and applicable local, state, and federal regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	02/10/2024

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45307 Based on record review and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 2 Physical Environment reportable incidents (#427073). The facility failed to complete a fire watch from 10:00 PM on 05/30/2023 through 8:00 AM 05/31/2023 while the fire alert system was offline. This deficient practice could place residents at risk of encountering fire. The findings included: Record review of fire watches, dated beginning 05/29/2023 at 9:00 AM reflected a fire watch was continuously in effect with 15-minute increment documented checks through 05/31/2023 at 1:30 PM apart from 10:00 PM on 05/30/2023 through 8:00 AM 05/31/2023 while the fire alert system was offline. Interview on 02/07/2024 at 1:12 PM, the ADM stated the original concern related to the fire panel was that it was giving a warning message to the fire prevention vendor that the facility contracted with. The ADM stated he was notified by this fire prevention vendor that until the problem is corrected, the fire prevention system was not operating as intended and might require a fire watch. The ADM stated he did not have further details related to the fire panel being inactive and deferred to his MS. Interview on 02/07/2024 at 1:45 PM, the MS stated he began the fire watch after the fire prevention vendor notified him on 05/29/2023 of the fire prevention outage and instructed the staff to continue the fire watch forms until it was repaired in a few days. The MS stated his responsibility did not include evaluating whether a fire watch was being continued and believed the staff who worked on the overnight shift on 05/30/2023 through 05/31/2023 was no longer an employee and could not be interviewed. The MS stated he was not interviewed related to this by the ADM or anyone else and was concerned with the local fire marshal inspection that took place several months following this incident. Facility policy related to fire prevention and fire watches was requested of the ADM on 02/09/2024 at 3:00 PM but was not given to the investigation team for review before exit.