

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Eagle Pass Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2550 Zacatecas Dr Eagle Pass, TX 78852	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse neglect for 3 of 5 Residents (Residents 1, 2 and 3) whose records were reviewed for abuse and neglect.</p> <ol style="list-style-type: none"> The ADM reported the Resident to Resident altercation involving Resident #1 and Resident #2 about 4 hours after he learned about the incident. The ADM reported an allegation of Resident Neglect after 4 hours after the incident took place. Resident #3 fell and sustained a fractured nose. <p>These deficient practices could affect any Resident and contribute to abuse and neglect.</p> <ol style="list-style-type: none"> Review of Resident #1's face sheet, 2/24/24, revealed he was admitted to the facility on [DATE], with diagnoses including Dementia with agitation and Cognitive Communication Deficit. <p>Review of Resident #1's quarterly MDS assessment dated [DATE] revealed her BIMS was 3 of 15 reflective of severe cognitive impairment.</p> <p>Review of Resident #2's face sheet, dated 2/28/24, revealed he was admitted to the facility on [DATE] with a diagnoses including Dementia without behavior disturbance, Anxiety and Depression.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 2/28/24, revealed his BIMS was 14 of 15 reflecting he was cognitively intact.</p> <p>Review of Provider Investigation Report, dated, 3/4/24 revealed on 2/26/24 at 12:45 PM Resident #1 hit Resident #2 on the right shoulder multiple times resulting in slight bruising to the shoulder. The incident took place in the dining room. CNA A intervened right away and removed Resident #1 from the dining room. Resident #2 stated he did not have pain and did not express any emotional distress. Upon interview Resident #1 did not remember the incident. Further review revealed the ADM reported an allegation of Resident abuse on 2/26/24 at 4:59 PM, over 4 hours after the incident took place and not within 2 hours per facility policy.</p> <p>Interview on 3/30/24 at 11:53 AM with the DON regarding the incident involving Resident #1 and Resident #2 revealed revealed she was working the floor, responded to the incident and told the ADM about the incident right away.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/30/24 at 2:30 PM with the ADM revealed staff told him about the incident involving Resident #1 and Resident #2 soon after the incident took place. He stated he was relatively new and it took him time to complete the reporting process. He stated he understood an allegation for Resident Abuse had to be reported within 2 hours and it was closer to 4 hours when he reported the Resident to Resident altercation.</p> <p>2. Review of Resident #3's face sheet, dated 3/29/24, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction and Other lack of Coordination.</p> <p>Review of Resident #3's annual MDS assessment, dated 3/3/24, revealed her BIMS was 11 of 15 reflective moderate cognitive impairment.</p> <p>Review of the facility Provider Investigation Report, dated 3/5/24 at 5:05 PM, revealed Resident #3 fell off her bed and sustained a laceration to her nose. The incident was unwitnessed. Resident #3 reported she was reaching for socks and hit the trash can next to her bed. Resident #3 was sent out to the hospital via EMS right away and X-rays revealed she had a fractured nose. The incident was reported at 9:34 PM.</p> <p>Interview on 3/30/24 at 2:30 PM with the ADM revealed staff told him about the incident involving Resident #3 soon after the incident took place. He stated he was relatively new and it took him time to complete the intake documentation. He stated he understood an allegation for Resident Neglect had to be reported within 2 hours and he reported the incident after 4 hours of learning about it.</p> <p>Review of facility policy, Abuse/Neglect revised 3/29/18, read: The facility will provide and promote the protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, abuse and situations that may constitute abuse or neglect to any resident in the facility. 3. Facility employees must report all allegations: abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designees will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 2 hours of the allegation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 2 hours after the allegation is made for 3 of 5 Residents (Residents 1, 2 and 3) whose records were reviewed for abuse and neglect.</p> <ol style="list-style-type: none"> The ADM reported the Resident to Resident altercation involving Resident #1 and Resident #2 about 4 hours after he learned about the incident. The ADM reported an allegation of Resident Neglect after 4 hours after the incident took place. Resident #3 fell and sustained a fractured nose. <p>These deficient practices could affect any Resident and contribute to abuse and neglect.</p> <p>Review of facility policy, Abuse/Neglect revised 3/29/18, read: The facility will provide and promote the protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, abuse and situations that may constitute abuse or neglect to any resident in the facility. 3. Facility employees must report all allegations: abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designees will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 2 hours of the allegation.</p> <ol style="list-style-type: none"> Review of Resident #1's face sheet, 2/24/24, revealed he was admitted to the facility on [DATE], with diagnoses including Dementia with agitation and Cognitive Communication Deficit. <p>Review of Resident #1's quarterly MDS assessment dated [DATE] revealed her BIMS was 3 of 15 reflective of severe cognitive impairment.</p> <p>Review of Resident #2's face sheet, dated 2/28/24, revealed he was admitted to the facility on [DATE] with a diagnoses including Dementia without behavior disturbance, Anxiety and Depression.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 2/28/24, revealed his BIMS was 14 of 15 reflecting he was cognitively intact.</p> <p>Review of Provider Investigation Report, dated, 3/4/24 revealed on 2/26/24 at 12:45 PM Resident #1 hit Resident #2 on the right shoulder multiple times resulting in slight bruising to the shoulder. The incident took place in the dining room. CNA A intervened right away and removed Resident #1 from the dining room. Resident #2 stated he did not have pain and did not express any emotional distress. Upon interview Resident #1 did not remember the incident. Further review revealed the ADM reported an allegation of Resident abuse on 2/26/24 at 4:59 PM, over 4 hours after the incident took place and not within 2 hours per facility policy.</p> <p>(continued on next page)</p>

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