STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675723	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Living Care Center	1475 Raynolds St El Paso, TX 79903

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observation, interview, and record review, the facility failed to ensure residents with Urinary Incontinence received appropriate treatment and services to prevent Urinary tract infections for 1 (Resident #5) out of 3 residents reviewed for quality of care. 1. The facility failed to ensure Resident #5's indwelling catheter tubing was not laying on the floor and he had a privacy bag on 08/07/2024 . 2. The facility failed to ensure Resident #5's subpubic catheter was properly secured to a leg strap on 08/08/2024 . This failure could place residents at risk of a Urinary Tract Infection and injury. Findings include: Record Review of Resident #5's Face Sheet dated 08/08/2024 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with a readmission on 07/03/2024. Record review of Resident #5's history and physical dated 02/01/2022, type 2 diabetes mellitus with unspecified complications, benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate). Record review of Resident #5's quarterly MDS assessment dated [DATE], revealed a severe impairment cognition BIMS score of 7. Record review of Resident #5's care plan dated 07/17/2024, revealed Resident #5 had a focus of an indwelling Foley 16fr with a 10cc N/S balloon. Resident #5 had a goal Resident will be/remain free from catheter-related trauma, with interventions to monitor and document intake and output as per facility policy, monitor of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. (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: 675723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/07/2024 at 10:04 AM, Resident #5 was sitting on his wheelchair in his bedroom. Resident #5 had catheter tubing rolled up and placed next to his leg side. His catheter bag was not placed in the blue privacy bag, but was hanging on the left side of the wheelchair touching the left wheel of the wheelchair. During an observation on 08/08/2024 at 10:00 AM, Resident #5 was observed lying in bed asleep. His catheter tubing was not secured onto resident's leg with a leg strap. In an interview on 08/07/2024 at 10:11 AM, CNA A stated that Resident #5 liked to place the bag on the left side of the wheelchair and did not have a leg strap and placed the tubing like that all the time. CNA A stated the tubing was wrong and should not be placed like that and the catheter bag should be placed at the front of the wheelchair in the bluebag. The risk would be that the urine did not flow down as it should and would not allow urine to flow properly and could cause a UTI for the patient. CNA A confirmed Resident #5 did not have a leg anchor for his catheter. In an interview on 08/08/2024 at 12:55 PM, LVN C said CNAs were reminded, as a second look, to ensure the tubing was not leaking and placed corrected on the leg strap . All catheters required a leg strap, there would be the risk if a resident did not have a leg strap, a risk of it coming out and injuring their urethra. In an interview on 08/08/2024 at 03:00 PM, the DON stated residents should have a leg strap, a stabilizer, or a band, but it was always the patches placed on for them . The nurses are the ones responsible for making sure they are put into place and secured correctly. The CNAs would notify nurses if anything is wrong, or the foley was scheduled every month to be changed. The foley should be checked daily by nurses, CNAs, or even the DON that saw it needed attention and would be fixed right away. DON and Surveyor went to confirm if Resident #5 a leg strap as DON stated all CNAs should know residents need the leg strap or at least let the RNs know residents do not have one on. DON stated that the resident did not have a leg strap. Resident was alert and oriented and trying to get out of bed. The Resident stated his foley did not hurt, but he did feel it tugging and was afraid it was going to come out. So to avoid him feeling that he placed the tubing under his leg and then moved so it did not pull. DON verified that resident should have had a leg strap on. In an interview on 08/09/2024 at 03:35 PM, the Administrator stated that he did not know how often they train for catheter care, and he would rather those questions be referred to his DON because he had no idea. In an interview on 08/08/2024 at 03:18 pm, RN B stated that catheters should be checked on every shift by the nurses and CNAs would advise if they need further attention. The risk of not having a leg strap on the resident or the tubing secured could be that it was pulled out of place and can cause skin breakdown to urethra and pain. RN B stated she did not receive any training from the facility regarding catheter care but knows from school. Record review of the facilities Catheter Care revised June 2019, and Perineal Care revised in December 2023 revealed policies did not state anything regarding leg straps. No other policy was brought forth prior to exit.