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	06/18/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 6 residents (Resident #12 and Resident #13) reviewed for dignity with meal assistance. The facility failed to ensure that Residents #13 and #14 were assisted with eating while staff were seated at eye level. This failure posed a risk of inadequate monitoring during feeding, which could result in, reduce dignity during mealtime, and hinder the ability to respond promptly to signs of distress. Findings included: Record review of Resident #12's face sheet dated 6/18/25 revealed an [AGE] year-old male was admitted to the facility on [DATE] with diagnoses of COPD (long term lung condition that makes it hard to breathe), dementia, (condition that affects the brain and makes it harder for a person to remember things, think clearly, make decisions, or take care of themselves) and altered mental status. Record review of Resident #12's quarterly MDS dated [DATE] revealed a BIMS 03, indicating his cognition was severely impaired. Functional abilities revealed he required set-up or clean-up assistance for eating and did not trigger any swallowing concerns. Record review of Resident #12's care plan dated 6/17/25 revealed a focus area for ADL self-care deficits with interventions that included EATING: Supervision with set up help staff assist. During an observation on 6/17/25 at 12:05 pm, Resident #12 was observed needing assistance with feeding. CNA B was assisting while standing and was not at eye level. Record review of Resident #13's face sheet dated 6/18/25 revealed an [AGE] year-old female that was admitted [DATE] with diagnoses of cognitive communication deficit, adult failure to thrive (usually an older adult experiences a noticeable decline in their overall health that isn't cause by just one specific illness) and stiffness of right shoulder. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's quarterly MDS dated [DATE] revealed a BIMS score of 04, indicating his cognition was severely impaired. The functional abilities section revealed she was independent for eating and did not trigger swallowing concerns. Record review of Resident #13's care plan dated 5/6/25 revealed a focus area for ADL Self Care Performance Deficit r/t generalized weakness with interventions that included requires supervision from staff participation to eat. During an observation on 6/17/25 at 12:01 pm, the SP was observed assisting Resident #13 with eating while standing up. The SP was not at eye level with Resident #13. During an interview on 6/17/25 at 12:06 pm, CNA C was observed bringing a chair to both the SP and CNA B so they could sit while assisting residents. During an interview on 6/17/25 at 12:39 pm, CNA C stated it was her third day in training. She stated she had received training on assistance with feeding and was informed that staff were expected to be seated at eye level. CNA C stated she observed both the SP and CNA B standing, so she brought them chairs. She stated staff were expected to sit at the resident's side and maintain eye level. She stated the risks of not doing so included an inability to properly monitor chewing and causing discomfort to the resident by requiring them to lift their head. During an interview on 6/17/25 at 3:36 pm, the DON stated that sitting while assisting with feeding was part of staff competencies. The DON stated that all staff assisting during meals were expected to sit in order to be at eye level with the resident, allowing them to observe if the resident was struggling with eating. The DON stated that this position was more comfortable for the resident and helped avoid neck extension. The DON stated that CNAs received training on dining assistance upon hire and annually. During an interview on 06/18/25 at 10:25 AM, with NP, she stated anybody giving feeding assistance needed to be trained. The NP stated the staff assisting with feeding needed to sit down while providing the food to the resident. The NP stated this was so that the staff assisting, and the resident were at the same level and the resident could feel relaxed and not rushed. The NP stated this was also for the staff assisting to monitor the resident by seeing them. During an interview on 6/18/25 at 2:06 pm, CNA B stated she recalled assisting Resident #12 with lunch the previous day. She stated the resident required cues and reminders, as he frequently fell asleep. CNA B stated she was aware she was standing during the assistance and that she was not supposed to be. She stated she received periodic training on dining assistance and that risks of not being seated included not being able to monitor and provide dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/25 at 2:26 pm, the SP stated that Resident #13 had recently returned from the hospital. The resident had been on a regular diet but came back with a downgrade to mechanical soft. The SP stated she wanted to observe for any mastication (the process of chewing food) issues and stated she did not observe any swallowing or chewing difficulties. She stated the resident had a reduced appetite related to her surgery and expressed nausea when eating too much. The SP stated she needed to continue monitoring the resident and that staff assisting with feeding should be seated at eye level. The SP stated she was primarily observing rather than feeding, and at the time there was no additional chair available. She stated that when helping or assessing, being at eye level was best. She stated that in most cases staff were seated, but when passing by, they try to get at eye level if offering assistance. No specific risks were stated, but she emphasized the importance of monitoring for swallowing concerns. Record review of the facility's Feeding- Assistance with eating dated 06/2019 read in part The qualified nursing staff will assist the patient/ resident who is unable to feed self in order to promote adequate nutrition and help the patient/resident enjoy a satisfying meal. Procedures: 10- sit down.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #14) reviewed for care plans. The facility failed to the implement a comprehensive person-centered care plan that addressed Resident #14's history of wandering. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings included: Record review of Resident #14's face sheet dated 06/18/25, revealed, admission on [DATE] to the facility. Record review of Resident #14's facility history and physical dated 02/12/25, revealed, an [AGE] year-old female diagnosed with altered mental status and UTI. There was no diagnoses of history of wandering. Record review of Resident #14's Clinical Risk Assessment generated by the DON dated 05/12/25, revealed, in section #3 - Predisposing Factors: was not coded for section F - History of Wandering. Record review of Resident #14's quarterly MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 3 to be able to recall and make daily decisions. Mood was not coded. Behaviors section E - Behavior was coded 0 for wandering -presence & frequency as behavior not exhibited. Record review of the facility Resident List of Wanders dated 06/18/25, revealed, Resident #14 to be on the list of wanders. Record review of Resident #14's Care Plan reviewed on 06/18/25, reviewed, there was no focus, goal, and intervention section for Resident #14 history of wandering. During an interview on 06/18/25 at 1:45 PM, with the DON, she stated she had provided a list of residents who resided in the facility that were wanderers. The DON stated her definition of wandering was a resident going from here to there without a specific point to include going into resident rooms. The DON stated Resident #14 did not have a wandering care plan in her care plan. The DON stated it should have been care planned because it was part of the resident's behavior and needed to be documented. The DON stated the MDS department was responsible for ensuring that it was care planned. The DON stated the purpose of the care plan was to provide the care for the resident and for everyone to know what the resident needed. The DON stated that was necessary for the care of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/18/25 at 2:29 PM, with the MDS, she stated it was the responsibility of the MDS department to ensure the care plans were correct. The MDS stated there was no wandering care planned for Resident #14 as she was not told that she had a behavior of wandering. The MDS stated it should have been care planned for Resident #14's wandering to be able to keep an eye on her. The MDS stated the purpose of the care plan was to notify the staff of Resident #14's wandering behaviors. The MDS stated the risk could be injury. During an interview on 06/18/25 at 2:46 PM, with the Administrator, he stated the facility had some residents who did wander the facility. The Administrator stated any resident who had a history of wandering or are displaying behaviors should be care planned. The Administrator stated the MDS department was responsible for ensuring the care plans were correct. The Administrator stated the purpose of the care plan was to identify areas that staff need to know of the resident information to be able to provide proper care for that resident. The Administrator stated the negative outcome of not care planning wandering could be missing something and not placing the interventions to provide the best care. Record review of the facility Care Planning dated 06/2019, revealed, Policy: It was the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to ensure records were maintained that were complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure that LVN A completed a personal inventory sheet for Resident #1 upon admission. This failure posed a risk of loss, misplacement, or unaccounted personal belongings, which could lead to resident dissatisfaction, grievances, and limited the facility's ability to verify personal items during the resident's stay or upon discharge. Finding included: Record review of Resident #1's face sheet dated 6/18/25 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of age-related cognitive decline. Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 02, her cognition was severely impaired. Record review of Resident #1's admission packet dated 2/13/25 revealed page 8: The Resident/Responsible Party shall complete an inventory form listing the Resident's personal items at the time of admission. Additions and deletions to the inventory shall be brought to the attention of the Facility's administration so that records are current. The Facility may ask the Resident to accept Resident's personal items for safekeeping. The Facility assumes no liability for the security of personal items retained by Resident or kept in the Resident's room. The Resident declines to authorize the Facility to hold Resident's funds in the Resident Trust Fund. The document was signed by Resident #1. Record review of Resident #1's admission inventory dated 2/13/25 revealed it was blank. No items were accounted for upon admission and/or was updated after admission. During an interview on 6/18/25 at 2:01 pm, the DON stated she could not locate an inventory sheet for Resident #1. She stated the first step during admission was completion of an admission assessment, and that most residents arriving from the hospital do not bring many belongings. She stated that if items such as purses or chargers were brought in after admission, a paper inventory should have been created. She stated she was unable to locate a paper inventory and that the nurses were responsible for completing it. The DON stated she reviewed the facility's policy and that she, along with the Assistant Directors of Nursing (ADONs), is responsible for overseeing inventory procedures. She stated she had not previously noticed the inventory sheet was missing and that failure to complete one poses a risk of being unable to account for resident belongings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/25 at 2:42 pm, the Administrator stated the inventory process is shared between the DON and the ADON, with assistance from a staff member in the laundry department. He stated he did not know Resident #1 and had not received any reports regarding missing money. The Administrator stated the BOM typically asks residents if they want valuables to be stored for safekeeping and that some residents prefer to keep their belongings on hand. He stated this conversation should be documented and that not securing belongings increases the risk of misplacement or loss. Record review of the facility admission - Documentation Guidelines Policy dated 06/2019, revealed, Guidelines - 1.) The assessment begins on the day the resident arrives. A. The record should show that a careful evaluation of the resident was made. 5.) It was the responsibility of the facility to account for all the personal belongings of the resident. A personal inventory list should be completed on admission and was part of the medical record.