| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675723 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Nazareth Living Care Center | 1475 Raynolds St<br>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.

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to consult with the resident's physician when there was a significant change in the resident's mental status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for one (Resident #3) of six residents reviewed for physician notification.-The facility failed to immediately consult with the Nurse Practitioner when Resident #3 was threatening to throw herself on the floor.This failure could place residents at risk of delayed medical treatment.Findings Included:Closed record review of the admission Record dated 01/23/26 for Resident #3 revealed, original admission date 12/24/25 and re-admission date 01/22/26.Review of the Hospital Physician Progress Note for Resident #3 dated 01/21/26 revealed, [AGE] year-old female history of fibromyalgia (a chronic condition causing widespread body pain, fatigue, sleep problems, trouble concentrating by amplifying pain signals, making people more sensitive to touch and discomfort), rheumatoid arthritis (is an autoimmune disease where the immune system mistakenly attacks the lining of the joints, causing chronic pain, swelling, stiffness, and inflammation, most commonly in the hands, wrists, and feet, but it can also affect other organs like the eyes, heart, and lungs), multiple sclerosis (is a chronic autoimmune disease where the immune system mistakenly attacks the myelin sheath, the protective covering of nerve fibers in the brain and spinal cord. This damage disrupts nerve signals, causing various symptoms like numbness, weakness, balance problems, vision issues, and cognitive difficulties, as the messages between the brain and body are slowed or blocked), COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra-mucus, and obstruction, and osteoporosis (a condition where bones become weak and brittle, making them more likely to break. Fall precautions.Review of the admission MDS assessment dated [DATE] for Resident #3 revealed, Entry Date: 12/24/25. Clear speech, makes self-understood, and understands others. BIMS Summary Score - 12 (cognition was moderately impaired). Verbal behavioral symptoms directed towards others screaming and cursing occurred for 1 to 3 days. Mobility device - wheelchair. Section GG - Functional Abilities dependent with oral hygiene, toileting hygiene, upper/lower body dressing, and personal hygiene. Section FF0170 Mobility - dependent with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and toilet transfer. Active Diagnoses: UTI (is a common bacterial infection in the system that makes and stores urine. It causes painful, frequent urges to urinate, burning sensation, cloudy urine, or lower stomach pain. It occurs when bacteria enter the urinary tract), Arthritis (General term for joint pain or joint disease meaning inflammation or swelling in one or more joints causing pain, stiffness and reduced movement. Often impacting daily activities) CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), Multiple Sclerosis, Depression (a serious mood disorder causing persistent sadness, loss of interest, and lack of motivation, affecting<br><br>(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 |
|---|---|---|

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | how the person feels, think, and act, differing from normal sadness by lasting long periods and interfering with daily life), COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction.Review of Resident #3's Nursing Note dated 01/21/26 at 11:19 a.m., written by LVN A revealed Resident #3 was yelling at 10:35 a.m. The writer went to check if the resident needed assistance. The resident threatened to throw herself on the floor.Review of Resident #3's Nursing Note dated 01/21/26 at 5:57 p.m., written by LVN B revealed Resident #3 continuously yelled and screamed throughout shift, repeatedly stating intent to throw herself out of bed and out of her wheelchair. The resident verbalized, not wanting to remain in facility. When asked about her needs, the resident cried and repeatedly stated she wanted to go home and continuously verbalized wanting to call 911. Will pass on report.Review of Resident #3's Nursing Note dated 01/25/26 at 1:54 a.m., written by LVN T revealed Resident #3 was making threats to throw herself on the floor and yelling.Review of Resident #3's Nursing Note dated 01/25/26 at 6:46 p.m. written by LVN U revealed the resident yelled out this nurse's name. Upon arrival to the room the resident was found lying on left side of her body near the bed with wheelchair pushed back from position it was in. The resident stated she leaned forward in the wheelchair could not stop herself and fell. The resident stated, I promise I didn't throw myself on purpose. When questioned why she was leaning forward the resident responded, I was trying to get my call light, The call light was clipped within reach on her night gown on the left shoulder. No injury/deformity noted. ROM assessment was hard to determine due to contractures and chronic issues with BLE, c/o pain to both knees and left elbow, and requesting tx. to hospital. Refusing x-rays ordered by the NP. The resident said, x-rays have misdiagnosed me before. Per the POA, they would like her to be transferred to the hospital.During an observation on 01/26/26 at 9:31 a.m., revealed Resident #3 was not in her room and all personal belongings and equipment had been removed from the room.During an interview on 01/26/26 at 9:34 a.m. with LVN A revealed Resident #3 had been sent to the hospital on [DATE] after she had sustained a fall in her room. LVN A said Resident #3 was yelling on Tuesday 01/20/26 and on Wednesday 01/21/26, and the resident had threatened to throw herself on the floor. He said the resident was anxious on those two days, and kept moving in bed, and kept asking the nurse and CNAs to sit her in her wheelchair. He said the resident kept asking for Tramadol but did not have an order for that medication. He said the resident was medicated with Tylenol #3 as ordered by the attending physician. He said he had not reported to the physician and/or the Nurse Practitionerhen Resident #3 made threats on Tuesday and Wednesday during the day shift to throw herself on the floor and that the resident kept asking for Tramadol. When the nurse was asked by the state surveyor why he had not reported this to the physician, he did not respond. He said they had been trained to immediately report to the physician and/or Nurse Practitioner when residents voiced threats to hurt themselves.During an interview on 01/26/26 at 10:25 a.m. with the DON and ADON revealed LVN U had called the ADON on 01/25/26 to report that Resident #3 had been found on the floor in her room. The ADON said LVN U had reported that Resident #3 was sitting in the wheelchair and did not want to go to bed. LVN U reported Resident #3 had said she was leaning forward to reaching the call light and fell off the wheelchair. The ADON said LVN U had not reported to her that Resident #3 had threatened to throw herself from the wheelchair. The DON and ADON said the nurses had been trained to immediately report to the attending physician and/or Nurse Practitioner when residents voiced threats to hurt themselves. The DON said the family member had sent a text message to the ADON informing her that Resident #3 had refused to return to the nursing home and the ambulance took her back home.During a telephone call on 01/26/26 at 11:38 a.m., with the Medical Director who was the attending physician for Resident #3 revealed<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the nurses had not reported to him when the resident was anxious and had threatened to throw herself on the floor on 01/21/26, and 01/25/26. He said that he expected the nurses to immediately report to him and/or the Nurse Practitioner when residents voiced threats to hurt themselves so they can evaluate the situation and determine what needed to be done for the resident.During a telephone interview on 01/28/26 at 10:36 a.m. with LVN T revealed, he had been assigned to Resident #3 on 01/25/26 during the night shift. He said the resident was confused at times, and recognized staff by names. He said that on that day the resident had a bad night, could not sleep, was turned and repositioned as requested by the resident due to discomfort to lower extremities. He said the resident used the call light for assistance. He said the resident had not sat in the wheelchair during the night shift on that day. He said Resident #3 was making threats to throw herself on the floor and yelling. He said they had been trained to report to the physician and/or the NP when residents made threats to hurt themselves. He did not say why he had not reported this to the physician. He said the resident's call light was kept within reach. He said he had been suspended on 01/25/26 by the DON and did not know why he had been suspended.During a telephone interview on 01/28/26 at 10:54 a.m. with LVN U revealed she had been assigned to Resident #3 during the weekend of 01/25/26. She said Resident #3 was alert, oriented to person, place, and time, was forgetful, required total assistance with ADLS due to left hemiplegia, often complained of pain to her back, hips, and legs, and was medicated with Tylenol #3 for pain as needed. She said the night nurse had not reported at the change of shift that Resident #3 was making any type of threats to hurt herself. She said that on that day during the evening shift, Resident #3 was yelling out her name and when she entered the room, the resident was lying on the floor next to her bed and was complaining about having pain at a level of 10, 10 being thend was sent to the hospital via EMS. She said the resident had said she was leaning forward to reach her call light. LVN U said the call light was clipped to the gown on the left side of shoulder and was hanging on her chest, so the call light was always kept within reach during her shift. She said the resident was assessed and had no visible injuries, had refused x-ray at the nursing facility and had been transferred to the emergency room per the POA's request. She said they had been trained to immediately report to the physician and/or NP when residents voiced threats to hurt themselves.During a telephone interview on 01/28/26 at 11:52 a.m. with Resident #3's family member revealed the resident had sustained a fall at the nursing home and had been transferred to the emergency room for evaluation. She said the resident had not sustained any injuries and had refused to return to the nursing home and returned home on Monday 1/26/26. She said the resident would be going to another city to live with a family member. The family member said Resident #3 had a stroke and had paralysis on one side of the body.Review of the facility's policy and procedures revised 6/2019, Subject: Change in Condition Communication. Policy: To improve communication between physicians and nursing staff to promote optimal patient/resident Care, provide nursing staff with guidance for making decisions regarding appropriate and timely notification of medical staff regarding changes in the patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition. Procedures: 1. Complete Assessment of the patient/resident which may include but is not limited to. Current physical condition, previous and current mental status, any interventions. 2. Complete SBAR. 3. Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's condition in the medical record. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications from enteral feeding for 1 (Resident #5) of 4 residents reviewed for enteral feeds.The facility failed to ensure Resident #5's water with enteral feed was administered according to physician's orders.This failure could place residents at risk of not receiving the proper hydration requirements prescribed by the physician.Findings included:Review of the admission Record dated 01/23/26 for Resident #5 revealed, original admission date 10/25/22 and re-admission date 01/05/26.Review of History and Physical dated 10/24/25 for Resident #5 revealed re-admission, [AGE] year-old male with past medical history of Parkinson, dysphagia (difficulty swallowing) and status post tube placement (feeding tube inserted directly into the stomach). Review of the Physician Progress Note dated 01/22/26 for Resident #5 revealed [AGE] year-old-male with history of COVID (contagious respiratory illness), pneumonia (common lung infection), status post peg replacement, urinary tract infection (common bacterial infection in any part of the urinary system).Review of Resident #5's Physician Order Summary dated 01/23/26 revealed Diagnoses: Parkinson's Disease and dysphagia (difficulty swallowing). NPO. Enteral Feeding Order Nutritional Formula 1.2 at 50 ml/hr. with 50 ml/Q 1 hr. free water flush via G-Tube feeding tube inserted directly into the stomach) continuously.Review of the Medication Administration Record dated January 2026 for Resident #5 revealed Enteral Feeding Order Nutritional Formula at 50 ml/hr. with 50 ml/Q hr. free water flush via G-Tube continuously.During an observation on 01/22/26 at 2:26 p.m. revealed Resident #5 was lying in bed, awake and was moaning, HOB, enteral feeding via G-tube, and the feeding pump's alarm was ringing. It was observed that the water bag hooked to the enteral pump was empty. The formula bottle was halfway filled. Resident #5 would not respond to verbal stimuli and was staring towards the window and did respond when the state surveyor talked to him.During an observation and interview on 01/22/26 at 2:29 p.m. with LVN C assigned to Resident #5 on the 6 AM-2 PM shift revealed she did not know that the feeding pump alarm was ringing. She said the alarm was ringing because the water bag was empty. The formula container of Nutritional Formula contained 50 ml of formula and was infused at 50 ml/hr., the bottle was dated 01/22/26 at 1:22 a.m., the empty bag of water was dated 01/22/26 at 1:22 a.m. by the 10 PM-6 AM nurse. LVN C said she checked the resident every two hours to ensure the enteral feeding was being administered according to physician's orders. She said the last time she had checked the resident was at 1:20 p.m., and there was water in the water bag. She said she could not recall the amount of water in the feeding bag on the last time that she had checked the resident.During an interview on 01/26/26 at 12:46 p.m., with DON revealed that the licensed staff had been trained to administer enteral feedings according to physician's orders. She said the licensed staff needed to check the enteral feedings during rounds to ensure that enteral feedings and hydration were being administered according to physician's orders.Review of facility's policies and procedures on Enteral Feedings revised 2023 revealed Policy: The facility will provide adequate care for residents with internal feeding tubes to prevent complications. Feeding/Flush Order: Facility will obtain physicians orders for enteral feeding (Formula in flush orders). Facility will follow physician orders and document feedings on electronic medication administration record. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided with such care, consistent with professional standards of practice for four (Resident #1, Resident #3, Resident #5 and Resident #6) of five residents reviewed for oxygen in that:-The facility failed to have a system in place of how to ensure the oxygen concentrators were maintained to ensure that Resident #1, Resident #3, Resident #5 and Resident #6 received oxygen at the prescribed flow rates.- The facility failed to ensure Resident #3's oxygen was administered continuously as ordered by the physician.-The facility failed to ensure Resident #5's oxygen was administered at 2 liters per minute instead of 1.5 liters per minute via nasal cannula as ordered by the physician.This deficient practice could affect residents who received oxygen continuously and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health.Findings Included:-Oxygen Concentrators:During a confidential interview on an undisclosed date at an undisclosed time revealed, the facility's oxygen concentrators were not serviced and maintained to ensure residents received oxygen at the prescribed flow rates. It was reported that the facility only cleaned the outside of the concentrators. It was reported that the QA tag on one of the oxygen concentrators that was being used by a resident had a QA sticker that reflected the oxygen concentrator was last serviced 10/04/2019. It was reported that the concern had been reported to the facility's Administrator.During an observation and interview on 01/22/26 at 2:59 p.m. with DON and ADON revealed they had not had a Central Supply worker for the past 9 months and the ADON was responsible for central supply and oxygen equipment. The ADON said that she did not know if the facility had a contract with an oxygen medical supplier to perform maintenance checks on the facilities oxygen concentrator or when was the last time that the oxygen concentrator had general maintenance by an oxygen medical supplier. It was observed that an oxygen concentrator was stored under the hand sink in the small Central Supply room in the Northeast Wing. The DON said it was stored there because it was not working. The oxygen concentrator was not labeled as being out of order. The DON said the oxygen concentrator should be labeled so it was not used and/or stored in a separate area. There were two oxygen concentrators stored in the room. The oxygen concentrators did not have QA stickers that indicated when the last QA service check was completed on the concentrators.During an interview on 01/23/26 at 10:35 a.m. with the Administrator, DON, and ADON revealed, they did not have a contract with an oxygen medical supplier to perform maintenance checks on the oxygen concentrators to ensure the machines were working properly. During an observation on 01/23/26 at 11:13 a.m. with the Administrator, DON, and ADON revealed, there were four concentrators stored in the Medical Room located on the Northwest Resident Unit. The oxygen concentrators stored in the Medical Room did not have QA stickers that indicated when the last maintenance checks were completed on the concentrators used at the facility by an oxygen medical supplier.Resident #1Closed Record Review of the admission Record dated 1/22/26 for Resident #1 revealed an admission date of 1/12/26 and discharge date [DATE] to an acute care hospital.Review of the Hospital admission History and Physical Note for Resident #1 dated 1/02/26 revealed, [AGE] year-old male with history of pulmonary fibrosis (is a serious progressive lung disease where tissue deep in the lungs becomes damaged, scarred, thick, and stiff. This scarring makes it difficult for lungs to function, restricting breathing and reducing oxygen flow to the blood stream. It is a chronic condition that worsens over time), chronic hypoxic hypercapnic respiratory failure (is a long-term, ongoing condition where the lungs cannot properly exchange gases, resulting in low oxygen and high carbon dioxide levels in the blood) and COPD (a progressive, irreversible lung disease that make breathing difficult by<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | damaging airways and air sacs and causing chronic inflammation/mucus). Patient comes with shortness of breath, worsening hypoxia and confusion. The patient was recently discharged to SNF. Assessment/Plan: Pulmonary fibrosis, worsening, encephalopathy (any disease, damage, or malfunction that affects the brain's function) due to hypercapnia and hypoxia. Patient is now on BiPAP. Pulmonary consult.Review of the Medical Transport Services Patient Care Report for Resident #1 dated 01/12/26 at 1:46 p.m. revealed Primary Impression: Hypoxemia, Secondary Impression: Shortness of breath. Oxygen saturation at 97%. Patient went to ED with c/o SOB and AMS, brought in by his family member. He was found to have elevated CO2 and in acute hypoxic failure. Past Medical History of HTN, COPD, and pulmonary fibrosis. Oriented to person, place, time and situation. Oxygen is on 6 L/min via nasal cannula.Review of the Physician Order Summary dated 01/22/26 revealed Resident #1 had an order dated 01/12/26 for Oxygen at 2-6L/min via nasal cannula continuously. Monitor oxygen saturation every shift. Ipratropium-Albuterol Solution 0.5 mg/2 ml inhale orally every 12 hours for SOB.Review of Resident #1's Nursing Facility's IDT Nursing Note dated 1/12/26 at 6:11 p.m. revealed Resident #1 was admitted from the hospital following episodes of altered mental status, hypoxia, pulmonary fibrosis and COPD. Resident #1 was on oxygen at 4-6 liters per minute.Review of the unsigned admission Assessment for Resident #1 completed at 4:54 p.m. revealed the resident arrived via EMS from the hospital with primary diagnosis of respiratory failure. Oxygen saturation was 80%, oxygen via nasal cannula. Alert oriented to person, place, and time, anxious, labored breathing/respirations, Oxygen 2-6 L/min.Review of Resident #1's Physician Note dated 1/12/26 at 6:18 p.m. written by the ADON for Resident #1 revealed, Late Entry: Did not get opportunity to evaluate patient as he was admitted on this date and decompensatedhortly after arrival. Notified to be in acute distress when bedside nurse notified me.Review of Resident #1's SBAR (Change of Condition) dated 1/12/26 at 7:04 p.m. revealed Resident #1 with worsening hypoxia, oxygen 74 % via nasal cannula. Worsening hypoxia, per family member resident not receiving enough oxygen through concentrator, requested to send him out.Review of Resident #1's IDT Nursing Note dated 1/22/26 at 7:09 p.m., revealed Resident #1 complaining of hypoxia and SOB, upon checking vitals noted BP 157/83, HR 122, Respirations 30, Oxygen at 6 L/min. Physician notified and gave new orders to transfer to ER via EMS. Resident #1 transferred to hospital, family member at bedside.Review of the Emergency Medical Services Report dated 01/12/26 at 6:35 p.m. for Resident #1 revealed onset of symptoms 01/12/26 at 3:00 p.m., shortness of breath. Oriented to person, place and time. Nursing home staff stated the patient was discharged from hospital after being admitted for hypoxia and when they received him his oxygen saturation was at 75% with 6 L/min of oxygen via nasal cannula at which point they contacted EMS. Patient reports past medical history of diabetes, hypertension, and COPD. Nursing home staff stated patient had just received an albuterol treatment. Pt. was found lying in bed in no apparent distress, speaking without difficulty, no increased work of breathing noted on 6 L/min via nasal cannula. Lung sound auscultation (listening to the internal sounds of the body, usually with a stethoscope) revealed diminished lung sounds in the bases. Pt. was placed on 10 L/min, oxygen saturation reading at 99. Patient placed on cardiac monitor and 12 lead performed showing sinus tachycardia (rapid heartbeat) Pt. was transported to hospital.During an interview on 01/22/26 at 3:54 p.m. with LVN E revealed Resident #1 had been admitted to the nursing facility directly from the ICU. She said the resident's oxygen saturation was at 73% upon arrival and was placed on 6 L/min oxygen via nasal cannula. She said the resident's family member said the resident was not getting enough oxygen via the portable oxygen tank. She said the resident was hyperventilating. During an interview on 01/22/26 at 5:10 p.m. with the Administrator and DON revealed that Resident #1's family member had called the Administrator and had reported the oxygen equipment did not deliver enough<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | oxygen. The Administrator stated that she did not recall the date that the resident's family member had called. It was reported that facility has standing orders for oxygen to administer 2-6 L/min via nasal cannula. The DON said the resident was initially placed on an oxygen concentrator at 5 l/min via nasal cannula and was changed to a portable oxygen tank to administer 6 L/min via nasal cannula. The Administrator stated that the family member kept asking for the name of nurse at the hospital who had given report to the nurses at the nursing facility upon discharge from the hospital.During a telephone interview on 1/23/26 at 10:13 a.m. with the attending physician for Resident #1 revealed, he was on the way to the facility on 1/12/26 to assess the resident when he had received a call from LVN E to report the resident had rapidly decompensated (condition worsen) and gave orders to transfer the resident to the ER via EMS. He said the discharge provider at the hospital specified the number of liters of oxygen to administer the resident, until the admitting MD went to assess the resident at the nursing facility. He said he remembered reviewing and approving the medication orders with LVN E. He said the residents were to continue the liters of oxygen ordered by the discharging provider, until he went to assess the resident at the facility.During an interview on 01/23/26 at 10:35 a.m. with the Administrator, DON, and ADON revealed the facility did not have a contract with a vendor to do service checks on the oxygen concentrators to ensure the oxygen concentrators were working properly to deliver the prescribed oxygen according to physician's orders. The ADON confirmed that the oxygen concentrator that was used had a QA tag dated 2019 She said, That concentrator is currently being used by another resident and there has been no issues with low oxygen saturation levels.During a telephone interview on 01/26/26 at 11:38 a.m. with facility's Medical Director revealed that he was aware that the facility had standing orders for use of oxygen for 2-6 L/min via nasal cannula and to monitor oxygen saturation levels every shift. He said, are prn oxygen order appropriate yes and no. Depending on the situation. This is not a hospital, and the physicians are not always on site, like in the hospitals. He said the nurses could adjust the liters up and down depending on the situation but if the oxygen level went beyond 6 L/min, the nurse would immediately send the resident to the hospital via EMS and then immediately notify the physician the resident was transported to the hospital. He said he was not aware that the facility did not have a system in place to have the oxygen concentrators serviced by a vendor to ensure the machines were working properly.During a telephone interview on 01/28/26 at 9:55 a.m. with the Vendor Administrator revealed his company had just signed a contract on 01/26/26 to check and provide general maintenance of the nursing facility's oxygen concentrators. He said oxygen concentrators required general maintenance of the exterior/interior filters, bacteria filter, oxygen % state required test for approved concentration above 90 % or higher to pass the test.Resident #3Closed Record Review of the admission Record dated 01/23/26 for Resident #3 revealed, original admission date 12/24/25 and re-admission date 01/22/26.Review of the Hospital Physician Progress Note for Resident #3 dated 01/21/26 revealed, [AGE] year-old female history of COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction), and osteoporosis (is a condition where bones become weak and brittle, making them more likely to break).Review of the admission MDS assessment dated [DATE] for Resident #3 revealed, Entry Date: 12/24/25. Clear speech, makes self-understood, and understands others. BIMS Summary Score - 12 (cognition was moderately impaired). Active Diagnoses: COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction); Shortness of breath on exertion. Oxygen continuous.Review of the undated Care Plan for Resident #3 revealed: Resident requires continuous oxygen via nasal cannula related to low oxygen saturation caused by COPD.Review of the Order<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Summary Report dated 01/23/26 for Resident #3 provided by Corporate Clinical Reimbursement Specialist on 01/23/26 revealed Oxygen at 1 L/Min via nasal cannula continuously. Monitor oxygen saturation every shift.Review of the Medication Administration Record dated January 2026 for Resident #3 revealed Oxygen at 1 L/Min via nasal cannula continuously. Monitor oxygen saturation every shift.During an observation on 01/23/26 at 4:12 p.m. revealed Resident #3 was sitting at the nurse's station talking to LVN B, and the resident did not have her oxygen on. When the surveyor asked LVN B if she had noted that the resident did not have her oxygen on, she said I did not notice it. The resident was not having shortness of breath and LVN B checked her oxygen saturation which was at 98%. Resident #3 said, Oh, I had not noticed that I did not have my oxygen on. LVN B wheeled the resident to her room and placed the oxygen cannula and set the oxygen concentrator at 1 L/Min. The resident said, It's my fault, I forget to use my oxygen.During an interview on 01/23/26 at 4:15 p.m., LVN B said they had been trained to check during rounds and as needed to ensure that the residents kept their oxygen cannula on when receiving continuous oxygen.During an interview on 01/23/26 at 4:24 p.m. with the DON revealed the nursing staff had been trained to check during rounds that residents did not remove their oxygen cannulas, to ensure residents were administered oxygen according to physician's orders.Resident #5Review of the admission Record dated 01/23/26 for Resident #5 revealed, original admission date 10/25/22 and re-admission date 01/05/26.Review of History and Physical dated 10/24/25 for Resident #5 revealed re-admission [AGE] year-old male with past medical history of Parkinson, dysphagia (difficulty swallowing) and status post tube placement.Review of the Physician Progress Note dated 01/22/26 for Resident #5 revealed [AGE] year-old-male with history of COVID, pneumonia, status post peg replacement (feeding tube inserted into the stomach), urinary tract infection (infection in the bladder caused by bacteria).Review of the Physician Order Summary dated 01/23/26 provided by Corporate Clinical Reimbursement Specialist on 01/23/26 revealed Diagnoses: Pneumonia, Dependence on supplemental oxygen, Shortness of breath, Acute and chronic respiratory failure with hypoxia, Parkinson's Disease. Oxygen at 2-3 L/Min via nasal cannula continuously. Monitor oxygen saturation every shift.Review of the Medication Administration Record dated January 2026 for Resident #5 revealed Oxygen at 2-3 L/Min via nasal cannula continuously. Monitor oxygen saturation every shift. During an observation and interview on 01/22/26 at 2:29 p.m. with LVN C assigned to Resident #5 on the 6-2 shift revealed the oxygen concentrator was turned on, and the resident's oxygen cannula was on top of his chest. She said the resident had an order for continuous oxygen at 2 L/min via nasal cannula. LVN C said the physician and FNP were aware that the resident frequently removed the oxygen cannula.During an observation on 01/23/26 at 4:20 p.m., revealed Resident #5's oxygen concentrator was turned on, and the liters were set 1.5 L/Min.During an observation and interview on 01/23/26 at 4:24 p.m. with DON revealed Resident #5's oxygen concentrator was turned on, and the liters were set 1.5 L/Min. She said the resident should be on 2 L/Min as ordered by the attending physician. She said the nursing staff had been trained to check that the oxygen concentrators were set at the prescribed liters and that oxygen cannulas were in place.Resident #6Review of the admission Record dated 01/23/26 for Resident #6 revealed, original admission date 10/24/25 and re-admission date 01/16/26.Review of History and Physical dated 10/24/25 for Resident #6 revealed Physician Progress Note dated 01/22/26 for Resident #6 revealed 53-year-female with diagnosis of asthma (is a long-term lung disease that causes the airways to become inflamed, swollen, and filled with extra mucus. It makes breathing difficult, by narrowing the air passages, leading to wheezing, coughing, chest tightness, and shortness of breath), pulmonary embolism with acute Cor Pulmonale (sudden right-sided heart failure that causes pulmonary obstruction), shortness of breath.Review of Physician Order Summary dated 1/23/25 for Resident #6<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | provided by ADON revealed Oxygen at 2-4 liters via nasal cannula continuously. Monitor oxygen saturation every shift.Review of the Medication Administration Record dated January 2026 for Resident #6 revealed Oxygen at 2-4 liters via nasal cannula continuously. Monitor oxygen saturation every shift.Observation and interview on 01/23/26 at 43:29 p.m. with ADON revealed Resident #6 was lying in bed, HOB elevated at 45 degrees, was awake. The ADON asked the resident how she was doing and the resident said she was doing fine. ADON demonstrated to the state surveyor the oxygen concentrator had a maintenance service tag dated 10/04/19. The ADON said they had just changed Resident #6 to the blue concentrator in her room because her oxygen was changed to 5 L/min. It was observed that the oxygen regular was at 5 L/min. and was being administered via nasal cannula.Review of facility's Nursing Policy and Procedure revised 8/2019 revealed, Subject: Oxygen Therapy: General Administration & Care; Policy: It is a policy of this facility that the facility will provide oxygen therapy by means of various administration devices. Procedures: Review physicians order on the chart for completeness: Modality, Liters, Frequency. (Note: For Oxygen Saturation below 89% Emergency use of oxygen from 2-4 L is appropriate to prevent worsening of hypoxemia and negative outcomes. The physician should be notified, and in order obtained for continued use of oxygen as soon as medically practicable. The facility did not have a policy on maintenance of oxygen concentrators. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #3) of 6 residents reviewed for pharmacy services.- The facility failed to ensure timely acquisition of Resident #3's Pregabalin and was not administered per physician's ordersThe failure could place residents at risk of inadequate therapeutic outcomes and a decline in health due to not receiving medication as ordered. Findings include:Closed record review of the admission Record dated 01/23/26 for Resident #3 revealed, original admission date 12/24/25 and re-admission date 01/22/26.Review of the Hospital Physician Progress Note for Resident #3 dated 01/21/26 revealed, [AGE] year-old female history of fibromyalgia(a chronic condition causing widespread body pain, fatigue, sleep problems, trouble concentrating by amplifying pain signals, making people more sensitive to touch and discomfort), rheumatoid arthritis (is an autoimmune disease where the immune system mistakenly attacks the lining of the joints, causing chronic pain, swelling, stiffness, and inflammation, most commonly in the hands, wrists, and feet, but it can also affect other organs like the eyes, heart, and lungs) , multiple sclerosis (is a chronic autoimmune disease where the immune system mistakenly attacks the myelin sheath, the protective covering of nerve fibers in the brain and spinal cord. This damage disrupts nerve signals, causing various symptoms like numbness, weakness, balance problems, vision issues, and cognitive difficulties, as the messages between the brain and body are slowed or blocked), COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra-mucus, and air flow obstruction), and osteoporosis (is a condition where bones become weak and brittle, making them more likely to break).Review of the admission MDS assessment dated [DATE] for Resident #3 revealed, Entry Date: 12/24/25. Clear speech, makes self-understood, and understands others. BIMS Summary Score - 12 (cognition was moderately impaired). Verbal behavioral symptoms directed towards others screaming and cursing occurred for 1 to 3 days. Mobility device - wheelchair. Section GG - Functional Abilities dependent with oral hygiene, toileting hygiene, upper/lower body dressing, and personal hygiene. Section FF0170 Mobility - dependent with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and toilet transfer. Active Diagnoses: Arthritis (General term for joint pain or joint disease meaning inflammation or swelling in one or more joints causing pain, stiffness and reduced movement. Often impacting daily activities) occasionally had pain with interference with sleep, day-to-day activities and Therapy Activities; Pain intensity Numeric Rating Scale (00-10) with ten as the worst pain - pain level at 7.Review of the Order Summary Report dated 01/23/26 for Resident #3 revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain.Review of the Medication Administration Record (MAR) dated January 2026 for Resident #3 revealed: -1/21/26 at Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain at 7:00 a.m., 1:00 p.m., and 7:00 p.m., no documented evidence the medication was administered. The MAR reflected code 8, see Progress Note.-1/22/26 at Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain at 7:00 a.m., 1:00 p.m., and 7:00 p.m., no documents evidence the medication was administered. The MAR reflected code 8, see Progress Note.-1/23/26 at Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain at 7:00 a.m., 1:00 p.m. and 7:00 p.m., no documented evidence the medication was administered. The MAR reflected code 8, see Progress Notes.Review of Resident #3's IDT Nursing Progress Notes revealed:Nursing Progress Note dated 01/22/26 at 8:00 a.m. written<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | by LVN A revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain med not available.- Nursing Progress Note dated 01/22/26 at 12:05 p.m. written by LVN A revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain med not available.- Nursing Progress Note dated 01/22/26 at 8:00 p.m. written by Med Aide V revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain med not available.- Nursing Progress Note dated 01/23/26 at 6:43 a.m. written by LVN A revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain med not available. The DON and NP are aware.- Nursing Progress Note dated 01/23/26 at 1:14 p.m. written by LVN A revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain med not available.- Nursing Progress Note dated 01/23/26 at 8:19 p.m. written by LVN B revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain pending.-Nursing Progress Note dated 01/24/26 at 7:43 a.m. written by LVN U revealed Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain not available from pharmacy.During a telephone interview on 01/16/26 at 11:38 a.m. with, the Medical Director revealed he was the attending physician for Resident #3. He said he was not notified by the nurses that Resident #3 had not received the Pregabalin according to his orders for several days in January 2026. He said he had a designated agent at the nursing facility who could order controlled substances from the pharmacy once the physician order was received. He said that he expected the nurses to administer medications according to physician's orders.During a telephone interview 0n 01/27/28 at 4:33 p.m. with the pharmacy customer service staff revealed that the order for Pregabalin had not been faxed to the pharmacy on 01/20/26. She said narcotics are not dispensed by the pharmacy unless they received confirmation from the physician. She said the nurses needed to follow up on narcotic orders with the pharmacy to ensure they had received the confirmation from the physician to dispense the medication. She said that according to their records the physician had not confirmed the order for the Pregabalin (Lyrica) Oral Capsule 50 mg give 1 capsule by mouth three times a day for pain because the nurses had not faxed the order to the pharmacy. She said the nurses should send the fax that includes the physician's telephone number for the pharmacy to obtain an electronic order or verbal confirmation from the attending physician.During an interview and record review on 01/27/26 at 5:15 p.m. with the DON and ADON revealed that licensed staff needed to fax the orders to the Vendor Pharmacy for controlled substances so the pharmacy could get the authorization to dispense the medication. The MAR dated January 2026 for Resident #3 revealed Pregabalin had not been administered as ordered on 01/21/26, 01/22/26, 01/23/26 and 01/24/26. The ADON said the licensed staff had been trained to follow up with the pharmacy after orders were faxed to ensure medications were promptly dispensed and available to administered according to physician's orders.Review of facility's Nursing Policies and Procedures revealed, Subject: Medication Administration and Management revised 6/2019 revealed, Procedures: The Facility's Medical Director will have an active role in the oversight of medication management. The facility's nursing and pharmacy services will identify that medications are ordered only when clinically indicated.Review of facility's policies and procedures on Ordering and receiving Medications revised on 08/2020 revealed, Policy: Medications and related products are received from the pharmacy on a timely basis. The facility maintains accurate records of medication, order and receipt. Procedures: I. Ordering medications from the pharmacy. Medications. Orders are written on the physician order form, Telephone order sheet, or reorder form from the pharmacy. The written entry includes: Date ordered. Whether the order is new or a repeat order. Resident's name, Medication name and strength, when indicated. Directions for use. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were accurately documented for 1 (Resident #1) of 6 residents reviewed for medical records. -The facility failed to ensure LVN B documented in the Nurse's Notes on 1/12/26 resident assessment when Resident #1 had a change in condition. - The facility failed to ensure LVN E documented in the Nurse's Notes on 1/12/26 when she called the physician to confirm medications orders for Resident #1 upon admission to the facility and when Resident #1 was transported to the hospital on [DATE] due to a change in condition.This failure could place residents at risk of resident's records not reflecting accurate and complete information. Findings include:Closed Record Review of the admission Record dated 1/22/26 for Resident #1 revealed an admission date of 1/12/26. discharge date [DATE] to an Acute Care Hospital.Review of the Hospital admission History and Physical Note for Resident #1 dated 1/02/26 revealed, [AGE] year-old male with history of pulmonary fibrosis (is a serious progressive lung disease where tissue deep in the lungs becomes damaged, scarred, thick, and stiff. This scarring makes it difficult for lungs to function, restricting breathing and reducing oxygen flow to the blood stream. It is a chronic condition that worsens over time), chronic hypoxic hypercapnic respiratory failure (is a long-term, ongoing condition where the lungs cannot properly exchange gases, resulting in low oxygen and high carbon dioxide levels in the blood) and COPD (a progressive, irreversible lung disease that make breathing difficult by damaging airways and air sacs and causing chronic inflammation/mucus). Patient comes with shortness of breath, worsening hypoxia and confusion. The patient was recently discharged to SNF. Assessment/Plan: Pulmonary fibrosis, worsening, encephalopathy due to hypercapnia and hypoxia. Patient now on BiPAP. Pulmonary consult.Review of Resident #1's Physician Order Summary dated 01/22/26 revealed Resident #1 had an order dated 01/12/26 for Oxygen at 2-6 L/min via nasal cannula continuously. Monitor oxygen saturation every shift. Ipratropium-Albuterol Solution 0.5 mg/2 ml inhale orally every 12 hours for SOB.Review of Resident #1's Nursing Facility's IDT Nursing Note dated 1/12/26 at 6:11 p.m. revealed Resident #1 was admitted from the hospital following episodes of altered mental status, hypoxia, pulmonary fibrosis and COPD. Resident #1 was on oxygen at 4-6 Liters Per Minute.Review of Physician Note dated 1/12/26 at 6:18 p.m. written by the ADON for Resident #1 revealed. Late Entry: Did not get opportunity to evaluate patient as he was admitted on this date and decompensated (condition worsen) shortly after arrival. Notified to be in acute distress when bedside nurse notified me. Review of SBAR (Change of Condition) dated 1/12/26 at 7:04 p.m. revealed Resident #1 with worsening hypoxia oxygen 74 % via nasal cannula. Worsening hypoxia, per son resident not receiving enough oxygen through concentrator, requested to send him out.Review of Resident #1's IDT Nursing Note dated 1/12/26 at 7:09 p.m. written by LVN B revealed Resident #1 was complaining of hypoxia and SOB, upon checking vitals noted BP 157/83, HR 122, Respirations 30, Oxygen at 6 L/min. The physician was notified and gave new orders to transfer to the ER via EMS. The resident transferred to the hospital 1/12/26, and his family member was at the bedside.During an interview on 01/22/26 at 4:08 p.m., with LVN B revealed she had assessed Resident #1 on 01/12/26 when the resident was yelling out and saying that he could not breath and had transferred the resident to the emergency room via emergency medical services on that day. She said she had not documented on 1/12/26 the resident's family member was in the room when the resident was transported to the hospital. She said she had not documented her assessment in the resident's clinical record on that day. She said they had been trained to document nursing assessments in the resident's electronic<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | records.During an interview on 01/23/26 at 2:24 p.m. with LVN E revealed she had placed a telephone call on 01/12/26 at 6:30 p.m. to Resident #1's attending physician to confirm medication orders upon admission to the nursing facility. She said she had placed a second telephone call to Resident #1's physician on 01/12/26 at 6:49 p.m., to let him know the resident had been sent to the hospital via EMS due to a change in condition. She said licensed staff had been trained to document in the resident's clinical records when they called the physician to obtain orders and/or report changes in condition. She said she had multiple admissions on that day and did not have time to document the physician's calls in Resident #1's clinical record. During an interview with the DON on 01/23/26 at 4:24 p.m. revealed the licensed staff had been trained to document in the residents electronic records when they completed resident assessments, and/or when they called the physicians and/or Nurse Practitioner to verify admission orders or when residents had a change in condition.Review of facility's policies and procedures on Clinical Documentation revised on 11/2025 revealed, Policy: The facility maintains accurate, timely, and resident centered clinical documentation. In the electronic record to reflect care provided in accordance with physician's orders. And the residents plan of care. Documentation supports continuity of Care. Clinical decision making and communication among the interdisciplinary team. The facility utilizes documentation by exception. Documentation should be completed as close to the time of care as possible. Accurate and reflective of care provided. Electronically authenticated with date and time/or shift. Documentation by Exception: Assessments are completed per facility practice and physician orders. When care does not occur as planned or a resident declines care, reflects the situation at a level appropriate to the circumstance. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to have an adequately equipped system that allowed residents to call for staff assistance through a communication system for 2 of 2 call light systems viewed for resident call system. The facility failed to ensure that residents' call lights in Rooms 254 and room [ROOM NUMBER] were functioning properly. This failure put residents at risk of not being able to call for assistance when needed. Findings included: During an observation on 01/26/26 at 1:40 p.m. revealed the nurse call lights were on for Rooms 268, 254 and 275 on the call light panel located behind the nurse's station. It was observed that LVN L answered the resident call light in room [ROOM NUMBER] and the call light was turned off. The resident call lights for rooms [ROOM NUMBERS] were on and did not ring at the nurse's stationDuring an observation and interview on 01/26/26 at 1:45 p.m. with LVN L revealed the resident was not in the room and the resident call light was not connected and was on top of the resident's bed. It was observed that the call light plate on the wall by the left side of the bed was taped to the wall with transparent tapend was loose. LVN L plugged in the resident call light and the call light would not stay in place, it would slightly slip out of the socket. LVN L said the resident pulled the resident call light out of the plug-in plate on the wall causing the resident call light plate to become loose. LVN L said the resident in room [ROOM NUMBER] was confused and did not use the nurse call light for assistance. He said the resident's son used the call light when he came to visit the resident and needed assistance.During an observation and interview 01/26/26 at 1:49 p.m. with Director of Support Services M revealed that the resident call lights, light domes in the hallway directly in front of room [ROOM NUMBER] and room [ROOM NUMBER] were not turned on. The state surveyor asked Director of Support Services M why the resident call lights were turned on the resident call light panel at the nurse's station and were not ringing. He said he did not know and was going to room [ROOM NUMBER] and room [ROOM NUMBER] to see what was going on. He demonstrated to the state surveyor that room [ROOM NUMBER] had dual nurse call lights and did not turn on in the room when he pushed the buttons. He went to room [ROOM NUMBER], which was directly across the hall from room [ROOM NUMBER], and demonstrated to the state surveyor that the call light did not turn on in the room or on the light domes in the hallway for rooms [ROOM NUMBERS] did not turn on when he pushed the call light button. He said that the nursing staff should have submitted a work order for the loose plug-in wall plate in room [ROOM NUMBER]. He said he was going to change the nurse call lights in these rooms right away.During an interview on 01/26/26 at 1:50 p.m. with CNA K revealed the resident in room [ROOM NUMBER] was confused and pulled the nurse call light off the plug-in plate on the wall and stored it in the nightstand drawers. She said the plug-in plate on the wall was loose and was taped to the wall with tape. She said she did not know if a work order had been completed to fix the plug-in plate on the wall. She said she had not noticed the call lights were on at the nurse call light panel at the nurse's station and were not ringing.During an observation on 01/26/26 at 1:52 p.m. revealed the Director of Support Services M was changing the nurse call lights in rooms [ROOM NUMBERS]. It was observed that the call lights were on at the nurse call light panel at the nurse's station and still were not ringing at the nurse's station.During an interview on 01/26/26 at 1:58 p.m. with LVN L revealed the residents in room [ROOM NUMBER] were not in the room. He said both residents were confused and did not use the nurse call lights.During an interview on 01/26/26 at 1:56 p.m. with Director of Support Services M, he said he conducted resident call light tests every two weeks and documented his findings. He said he had not found any problems with the nurse call lights not working on the last check and could not remember when the last check was<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675723 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Nazareth Living Care Center | 1475 Raynolds St<br>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.

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | completed. The state surveyor requested to see the nurse Call Light tests reports.During an interview on 01/26/26 at 2:11 p.m., with Director of Support Services M in the presence of the Administrator, he said he did not have any documentation of the resident call light tests that he said he completed every two weeks. He said one of the resident call lights on the dual call light cord was not working and that was why the call light dome did not light up and ring at the nurse's station. He said he had just created a Call Light Test QA sheet to document his findings. The Administrator said she was informed by the facility's corporate staff that they did not have a policy & procedures on call lights. |