STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675831	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review, the facility failed to ensure the right to receive written notice of a room change before the change was made for 1 of 6 (Resident #61) residents reviewed for right to receive written notification. The facility failed to provide Resident #61 a written notice of a room change before the resident was moved. This failure could place all residents at risk of being displaced without notice and/or reason and decrease of quality of life being in a new environment. Findings included: Record review of Resident #61's face sheet dated 3/14/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #61's history and physical dated 01/17/2024 revealed diagnoses of anxiety, dementia, and other recurrent depressive disorders. Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, her cognitive was intact. Record review of Resident #61's care plan dated 01/16/24 revealed Resident #61 had history of false accusations and being critical of staff has expressed verbally aggressive behavior. Record review of Resident #61's SW progress note dated 1/26/24 and signed by SW on 1/26/24revealed resident set for room change. Notified by central supply who was assisting in the room that [Resident 61] was wanting to speak to Administrator. SW and Administrator headed to room [ROOM NUMBER]. [Resident 61] verbalized she did not want to move to 404. The administrator then notified the resident that she was not able to remain in that room due to reports received. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675831	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #61's SW progress note dated 2/8/24 and signed by SW on 3/11/24 revealed meeting in private dining room with local Ombudsman, Administrator, SW, Resident #61, and 2 of Resident #61 family members. Meeting regarding room change for resident on 1/26/24. Resident #61's family member began by vernalizing dissatisfaction with the room change and how the situation was handled by facility. Resident #61's family member how chaotic she remembers the situation being when she arrived. The administrator explained the situation that transpired and Resident #61's family member stated expressed how she felt his (the administrator) demeanor came across as callous through the way he spoke. SW also explained the situation, reiterating that in the moment both parties, [Resident #61] and roommate had to be assessed and action had to be taken to deescalate the situation. The family of roommate had reported that [Resident #61] was being verbally aggressive towards them upon admission. During the discussion with [Resident #61] she denied the verbal aggression. Due to previous verbal conflicts reported by previous roommates. The administrator notified the resident she would be moved to a different room. Resident #61's family member continued to express dissatisfaction with the situation and verbalized being upset with staff. Family to be notified of any and all changes with resident and all aspects of care. Record review of Resident #61's Ombudsman case file revealed case was opened on 2/2/24. Intake summary read in part phone call from [Resident #61] that administrator forcefully took her out of her room and slap her hand. Left her at the hallway to be transfer to another hallway isolated from other residents. [Resident #61] stated that the family member of the roommate complaint about something that [Resident #61] said the night before and administrator kick her out of her room. Further review of the case file revealed : *dated 2/24/24 read in part [Resident #61] stated that the Administrator informed her that the roommate family who was placed the night before had complaint about her and told her that she needed to leave the room without given her the five days' notice or no investigation of what was the situation of the complaint. The Social Worker told [Resident #61] that she was going to contact the Managing Local Ombudsman (MLO) for a meeting for further discussion, but until this date social worker has not contact the Ombudsman. MLO obtain consent to report the incident to CII, which MLO did that same day. *dated 2/8/24 read in part MLO attended a care plan meeting with a complaint with a resident about an incident that happened on 1/25/24 with [Resident #61] and the roommate. We discussed the incident and according to administrator he already spoke with resident about moving her to another room which she agree but once she saw the room she didn't wat to transfer. The roommate's family stated to the staff that [Resident #61] told them in an aggressive and ugly way to get out of her room. Then the Administrator decided to move her right away due to the complaint, he wanted to avoid any conflict between [Resident #61] and the family. MLO mentioned about State regulations that they were not implemented, and resident rights were violated. [Resident #61] has never got aggressive, and she wanted a better explanation but there was no proper investigation. [Resident #61] and her family are not happy with the way administrator handles the situation, and her family knows [Resident #61] can be difficult. Family was not involved to remedy the situation before or after the incident. [Resident #61]'s family member did ask the administrator to keep them involved to assist in the situation with [Resident #61], so the previous incident won't happen again like [Resident #61] describe it. The Administrator agreed to keep the family on the loop whenever there is a situation with [Resident #61]. [Resident #61] did share in the meeting that she was scared of the Administrator because he has threatened her that he is the one who governs the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/24 at 10:00 am, Resident #61 was alert and oriented to person, place, time, and event. Resident #61 stated she was moved rooms little over a month ago due to a new roommate who had placed a complaint about her. Resident #61 stated she had questioned the Administrator on why she was moved and was told he had received enough complaints of her and had decided she would have to be the one moved out of the room. Resident #61 stated she did not receive a written notice regarding the room change. Resident #61 stated she felt intimidated and humiliated. During an interview on 3/11/24 at 10:51 am, the Ombudsman stated he had received a call from Resident #61 who had stated that she had been forcefully removed from her room by the Administrator. A call was placed to Resident #61's RP on 3/11/24 at 11:13 am, phone call was not answered and VM box was full. The surveyor was not able to leave VM to return the call. The call was not returned by the time of survey exit. During an interview on 3/11/24 at 11:28 am, the SW stated Resident #61 had been moved rooms a few weeks back due to a complaint from roommate that she had been verbally aggressive with her. The SW stated herself and the Administrator had suggested the room change to Resident #61 who had verbalized understanding at the time. The SW stated the facility then decided to move her belongings to the new room, and when the staff went to move her belongings Resident #61 had become upset and requested to talk to the Administrator. The SW stated the facility had a meeting with the Ombudsman, Resident #61, the Administrator, the SW, and 2 of Resident #61's family members on 2/8/24. The SW stated because of the nature of the complaint and history of Resident#61 having issues with roommates, the Administrator had decided to move her rooms and possibly finding her a room to herself. During an interview on 3/11/24 at 3:43 pm, the Administrator stated Resident #61 had a history of conflict with roommates in the past. The Administrator stated Resident #61's roommates' family had complained of her being verbally aggressive. The Administrator stated because of the history Resident #61 had with conflicts with other roommates, he decided to move her and had spoken to her about moving rooms. The Administrator stated Resident #61 was shown the room across and eventually moved hallways entirely where she could have a room by herself. The Administrator stated a 5-day written notice was not provided to Resident #61 because he wanted to prevent the situation from escalating with both residents. Record review of Room Change/Roommate Assignment policy dated May 2017 read in part changes in room or roommate assessment shall be made when the facility deems it necessary or when the resident requests the change. Prior to changing a room or roommate assessment all parties involved in the change/assessment (e.g., residents and their representatives) will be given a _ hour/day notice advance notice of such change. Advance notice of roommate change will include why the change in being made and anu information that will assist the roommate in becoming acquainted with his or her new roommate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interviews and record review the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 6 (Resident #61) of 6 reviewed for allegations of abuse. The facility failed to ensure the Administrator followed internal abuse policy, report allegations of abuse to State Office, and conduct thorough abuse allegation investigation. These failures could place all residents at risk of continued abuse by not immediately following the facility policy of abuse, neglect, exploitation, or misappropriation - reporting and investigating. Findings included: Record review of Resident #61's face sheet dated 3/14/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #61's history and physical dated 01/17/2024 revealed diagnoses of anxiety, dementia, and other recurrent depressive disorders. Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, her cognitive was intact. Record review of Resident #61's care plan dated 1/16/24 revealed Resident #61 had history of false accusations and being critical of staff has expressed verbally aggressive behavior. Record review of TULIP revealed no self-report for Resident #61's allegation of slap in hand by the Administrator. Record review of Resident #61's SW progress note dated 1/26/24 and signed by SW on 1/26/24revealed resident set for room change. Notified by central supply who was assisting in the room that [Resident 61] was wanting to speak to Administrator. SW and Administrator headed to room [ROOM NUMBER]. [Resident 61] verbalized she did not want to move to 404. The administrator then notified the resident that she was not able to remain in that room due to reports received. The administrator then wheeled the resident towards the door into the hallway where [Resident #61] continuously stated she was not moving to 404. Administrator and SW discussed, and administrator identified room [ROOM NUMBER] as available for resident to go into private room. [Resident #61] was notified she would go into private room and verbalized no concern. [Family member] then appeared in hallway and SW and administrator spoke with [Family Member] to inform her of events that transpired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #61's SW progress note dated 2/8/24 and signed by SW indicated .[Resident #61] expressed that the Administrator had forced her wheelchair out of the room stating that at one point, she held her hand to the wall where removed the hand from the wall. In previous conversations with resident, she had stated the Administrator had forced her out of the hallway but did not mention it being a physical matter . Record review of Resident #61's Ombudsman case file revealed case was opened on 2/2/24. Intake summary read in part phone call from [Resident #61] that administrator forcefully took her out of her room and slap her hand. Left her at the hallway to be transfer to another hallway isolated from other residents. Journal entries dated 2/24/24 read in part [Resident #61] reported to the Ombudsman that the administrator physically assault her by forcefully taken her out from her room. [Resident #61] stated that this incident happened on January 25th, 2024. [Resident #61] stated that the Administrator grab her wheelchair and push her out of her room, she put her wheelchair brakes to stop him to further discuss the situation about the complaint because she was not aware of an issue. The Administrator continue to push her with the wheelchair when [Resident #61] grab the door frame and the Administrator slap her hand so she can let go at the door frame. He (the administrator) continue to push her out of the room and finally left her at the hallway. Staff took her to the new assigned room in an isolated hallway. [Resident #61] feels humiliated, retaliation, threaten by the administrator that he will be discharging her, feels abused by the administrator and her resident right been violated. [Resident #61] has stated that Administrator has told her many times he is the one with the authority at the facility and makes the final decisions. The Social Worker told her that they were going to move her again to another room but she did not specify when. [Resident #61] stated she does not want to be moved out of the facility, but feels the administrator will forcefully move her out. The Social Worker told [Resident #61] that she was going to contact the Managing Local Ombudsman for a meeting for further discussion, but until this date social worker has not contact the Ombudsman. MLO obtain consent to report the incident to CII, which MLO did that same day. Journal entry dated 2/8/24 read in part MLO attended a care plan meeting with a complaint with a resident about an incident that happened on 1/25/24 with [Resident #61] and the roommate. [Resident #61] inform MLO that administrator forcefully took her out from her room to be transfer to another room. Also, [Resident #61] stating that he (the administrator) did slap her arm so she can let go at the door frame so he can push her wheelchair. During an interview on 3/11/24 at 10:00 am, Resident #61 was alert and oriented to person, place, time, and event. Resident #61 stated she was moved rooms little over a month ago due to a new roommate who had placed a complaint about her. Resident #61 stated when she was moved, the Administrator had forcefully kicked her out of the room by pushing her wheelchair out and placed her in the hallway. Resident #61 stated as the Administrator was pushing her out of the room in the wheelchair, she had attempted to put the brakes on the wheelchair to prevent him wheeling her out and it was unsuccessful. Resident #61 stated she then placed her hand on the door frame prior to exiting the door in attempts of resisting being pushed out all the way, and the Administrator had slapped her hand to get her to remove her hand from the door frame. Resident #61 stated she called the Ombudsman and had notified him of the incident where she was forced out of her room and the Administrator slapping her hand. Resident #61 stated she had also told the SW of the situation, and nothing had been done. Resident #61 stated she felt scared, intimidated and humiliated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER: Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE: 10880 Edgemere Blvd El Paso, TX 79935	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 3/11/24 at 10:51 am, the Ombudsman stated he had received a call from Resident #61 who had stated that she had been forcefully removed from her room by the Administrator. The Ombudsman stated Resident #61 gave details when she was forced out of the room by the Administrator and said he (the administrator) had slapped her hand when she placed her hand on the door frame to prevent being pushed out of the door all the way. A call was placed to Resident #61's RP on 3/11/24 at 11:13 am, phone call was not answered and VM box was full. The surveyor was not able to leave VM to return the call. During an interview on 3/11/24 at 11:17 am, the DON stated she was aware Resident #61 had been moved rooms a few weeks back but was not aware of details regarding the move. The DON stated she was not notified of Resident #61 allegation of being slapped in the hand by the Administrator. The DON stated she did not know who she would report the allegation of slap in the hand if the alleged perpetrator was the abuse coordinator but would have to report to State Office. During an interview on 3/11/24 at 11:28 am, the SW she did not recall Resident #61 alleging a slap in the hand by the Administrator. The SW stated she did not have a progress note and/or documentation regarding the 2/8/24 meeting. The SW stated the Administrator was the abuse coordinator and did not know who she would report an allegation of abuse when the Abuse Coordinator/ Administrator was the alleged perpetrator. The SW stated she did not report the allegation of slap in the hand because she did not recall that topic mentioned during the meeting held on 2/8/24. During an interview on 3/11/24 at 3:43 pm, the Administrator stated he did not report the allegation Resident #61 had made against him regarding the slap in the hand because there were witnesses in the room and the meeting was held with the Ombudsman to discuss what had transpired. The Administrator stated he was the abuse coordinator and if an allegation was made against him someone else would have to report and/or investigate the allegation. The Administrator stated the SW was aware of the allegation and had gathered witnessed statements from the witnesses in the room. The Administrator stated he did not provide a statement and was not suspended pending investigation due to him not having direct care with the resident. The Administrator stated based on abuse policy the allegation Resident #61 had made about him hitting her should had been reported to State Office. During an interview on 3/11/24 at 5:13 pm, the Administrator stated today was the first time he heard allegation that he hit her (Resident #61) and he denied having done that. The Administrator said he would be suspended pending investigation and Corporate Director of Operations would conduct the investigation. During an interview on 3/12/24 at 8:34 am, Maintenance staff stated he was asked by the Administrator to assist with Resident #61's move to a different room. The Maintenance staff stated that Central Supply and him, had gone to Resident #61's room to start gathering her belongings and she had become upset and requested to speak to the Administrator. The Maintenance staff stated the Administrator had gone to Resident #61's room and discussed the room change that had been agreed to. The Maintenance staff stated his back was facing the door and had not seen the Administrator assist Resident #61 out the room. The Maintenance staff stated because his back was facing the door he did not see the Administrator slap Resident #61. The Maintenance staff stated he did not hear anything concerning noise, Resident #61 was only very upset and arguing with the Administrator. The Maintenance staff stated Central Supply was in the room and may have seen any interaction between the Administrator and Resident #61. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 3/12/24 at 8:53 am, Central Supply stated she had been asked to assist Maintenance staff with gathering Resident #61 belongings for room change. Central Supply stated when they both were in Resident #61 room she became upset and had requested to speak to the Administrator and had stepped out to get him. Central Supply stated when the Administrator came to Resident #61 came to the room, she stayed by the restroom area where it was few feet away from the bed and saw him talking to her. Central Supply stated she appeared very upset and does not know what was said because she did not speak Spanish. Central Supply stated he saw the Administrator wheel Resident #61 out of her room and did not see him put any hands on Resident #61. Central Supply stated she did not see the Administrator slap Resident #61's hand. During an interview on 3/13/24 at 11:28 am, Executive Director of Clinical Services stated they had been notified of Resident #61's allegation of slap in the hand by the Administrator. The Executive Director of Clinical Services stated the Corporate Director of Operations was the lead investigator in the case. The Executive Director of Clinical Services stated whoever was present during the meeting with the Ombudsman when the allegation was brought should have reported it to the corporate office and State Office. The Executive Director of Clinical Services stated it was expected for the SW and even the Administrator to have reported the alleged incident immediately. The Executive Director of Clinical Services stated failure to report any allegation of abuse could result in failure of investigation to be completed and alleged perpetrator still working in the facility. A call was placed to Resident #61's RP on 3/12/24 at 9:01 am, phone call was not answered and VM box was full. The surveyor was not able to leave VM to return the call. The call was not returned by the time of survey exit. During an interview on 3/12/24 at 12:35 pm, Resident #61 stated the SW had gone to speak to her regarding the allegation against the Administrator this morning. Resident #61 stated she was asked if she had any other information she wanted to share and was told they'd be checking in on her weekly to see how she was doing. Resident #61 stated she felt better knowing the facility was taking her allegation serious and something was being done. During an interview on 3/13/24 at 2:35 pm, Corporate Director of Operations stated she was notified of Resident #61's slap in hand allegation on Monday 3/11/24 and immediately suspended the Administrator. The Corporate Director of Operations said the abuse policy should have been followed regardless of witnesses in the room due to the allegation. The Corporate Director of Operations stated it was expected for the SW and the Administrator to have reported the allegation immediately to the corporate office and State Office. The Corporate Director of Operations stated she followed up with the Administrator who denied slapping Resident #61's hand. The Corporate Director of Operations stated the DON had called in the abuse allegation to State Office and had requested assistance from the SW to gather statements and interview other residents while the Executive Director of Clinical Services arrived to the facility to assist onsite. The Corporate Director of Operations stated she finished reviewing the interviews and statements gathered Monday (3/11/24) evening and because there was a witness who saw the interaction the allegation was inconclusive and cleared the Administrator to return to work on Tuesday 3/12/24. The Corporate Director of Operations stated she completed a one0to-one in-service with the Administrator and DON regarding reporting abuse allegations being reported to ensure investigation is thoroughly conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy dated April 2021 read in part all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting allegations to the Administrator and Authorities: 2) the administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility; immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for three of three hallways and 1 resident (Resident #283) of 14 residents observed for infection control practices during enteral feeding. -The facility failed to store contaminated resident equipment in the designated storage area. -The facility failed to store reusable water containers off the floor in the Therapy Room. -The facility failed to store supply boxes off the floor in storage rooms. -The facility failed to prevent cross contamination was not storing clean and dirty equipment on separate racks. Findings included: Linen Rack; Linen Hampers: Observation on 03/11/24 at 9:29 AM, revealed clean linen cart cover had a hole on the right side approximately the size of a nickel. Observation on 03/11/24 at 9:30 AM, with LVN B revealed 1 yellow linen hamper was in the hallway and the cover was slightly open. LVN B stated linen hampers should be closed and stored in shower rooms when not in use. Interview on 03/14/24 at the Maintenance Director stated the linen cart covers should be free of holes to prevent contamination of clean linen. Equipment: Observation on 03/11/24 at 9:35 AM, revealed three oxygen concentrators, one feeding pole with attached feeding pump, one plastic 3 drawer cart that contained PPE, and one nebulizer machine were stored in a connecting hallway between 100 and 200 hallways. Interview on 03/11/24 at 9:44 AM, with the Activities Staff reported that he worked in the activities department and was covering for the Central Supply Clerk because she was on leave. He reported that he was not sure why the equipment was stored in the hallway that connects 100 and 200 hallways. Interview on 03/11/24 at 9:45 AM, the DON revealed that the equipment that was stored in the hallway that connects the 100 and 200 hallways had been removed from the resident rooms because residents were discharged , and 1 oxygen concentrator was not working. She stated the equipment had been there for a couple of days and did not know where the equipment should be stored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Therapy Room: Observation on 03/11/24 at 9:39 AM, revealed seven 6 emptied 5-gallon reusable water bottles and one full 5-gallon reusable water bottle were stored on the floor directly across the water dispensing machine in the therapy room. Interview on 03/11/24 at 9:40 AM, COTA (certified occupational assistant) revealed that the 5-gallon reusable water bottles were always stored on the floor close to the water dispensing machine in the therapy room. Supply Storage Rooms in 100 and 200 Halls: 200 Hall Soiled Utility Room: Observation on 03/14/24 at 9:39 AM - 10:01 AM with the ADON and Central Supply Clerk revealed: -Mop Basin had black substance around the sides and area around the drain. -Six commercial paper roll towels were stored on a rack and a large container that had dark brown substance in the bottom, black cover was full of dust and brown and white particles, stored next to two vacuum cleaners that were covered with dust and dried stains. The plastic pallet was full of dust, covered with dried black stains, and paper particles. -Metal side rails were stored on the floor. -The large black plastic rack was full of dust and covered with white dried stains, 22 torn, dusty floor mats were stored on the rack. There was a Faucet Connector hanging from the side of the storage rack. There was a mop bucket stored next to the rack where floor mats were stored. Multiple empty boxes were stored on the floor next to a gray trash hamper. 100 Hall: Observation on 03/14/24 at 10:05 AM with the ADON and Central Supply Clerk revealed room [ROOM NUMBER] was being used as a storage room: The ADON reported that Hall 100 was temporarily closed and was designated as the COVID unit whenever they had a COVID outbreak. The door to the room was open. There was a sign posted on the door to Keep Door Closed at All Times. Many cardboard boxes were stored on the floor. The ADON stated some of the boxes opened and contained COVID testing kits. There was a mattress stored on the floor. There were two large cardboard Storage File Boxes that contained papers stored on the floor next to the entrance to the bathroom. Storage Room located in Hallway that connects the 100 and 200 Halls revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/14/24 at 10:05 AM with the ADON, Maintenance Director, and Central Supply Clerk revealed 3 oxygen concentrators, 1 enteral feeding pump attached to IV pole, 1 drawer storage cart that contained PPE, and 1 nebulizer machine that had been removed from resident rooms and had not been disinfected were stored in the storage room with the clean supplies in the same storage room. The ADON stated she did not know who had stored the contaminated equipment in the clean storage room. It was observed that boxes of briefs and enteral formulas were stored on the floor next to the contaminated equipment. The ceiling light was missing cover. There was a large brown water stain above ceiling light that extended to the area where supply boxes were stored on the floor. Central Supply Room located in 200 Hall: Observation on 03/14/24 at 10:05 AM with the ADON and Central Supply Clerk revealed: Boxes of supplies were stored on the floor. Review of facility ' s undated policy and procedures on Cleaning and Disinfection of Environmental Surfaces revealed: Policy Statement-Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standards. Policy Interpretation: The following categories are used to distinguish levels of sterilization/disinfection necessary for items used in resident care and those in the resident ' s environment. Non-critical items are those that come in contact with skin but not mucous membranes. (1) Non-critical environmental surfaces include bed rails and floors. Housekeeping surfaces (e.g. floors) will be cleaned on a regular basis, when surfaces are visibly soiled. Walls in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.