

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  07/19/2024
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</b></p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of needs for 1 (Resident #2) of 6 residents reviewed for call light button placement.</p> <p>-The facility failed to ensure that Resident #2's call light was within her reach.</p> <p>These failures could place residents at risk of not being able to have their needs met.</p> <p>Findings included:</p> <p>Review of Resident #2's Face Sheet dated 07/10/2024, revealed a [AGE] year-old female, with an admitted [DATE]. Resident #2's diagnoses included: weakness, functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), neuromuscular dysfunction of bladder (nerves and muscles don't work together very well causing lack of bladder control), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), unsteadiness on feet, pain, and history of falling.</p> <p>Review of Resident #2's quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 10 indicating moderate cognitive impairment. Section on Functional Abilities and Goals revealed Resident #2 with impairment to one side of the upper and lower extremities. Resident was dependent on staff assistance for oral hygiene, toileting, bathing, dressing, personal hygiene, and transfers.</p> <p>Review of Resident #2's comprehensive care plan dated 07/10/2024, revealed the resident was at risk for falls with injury related to weakness. Part of the interventions included, Keep call light in reach and encourage to use.</p> <p>During an observation and interview on 07/03/2024 at 11:01 a.m., Resident #2 was lying in bed. Observed resident's call button was hanging over an oxygen concentrator positioned approximately a foot and a half away from the resident. Resident #2 said she could not reach the button from where she was. Resident #2 shrugged her shoulders when asked if she needed to contact facility staff, how would she do so with her button being out of reach.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 07/03/2024 at 11:10 a.m., LVN C entered Resident #2's room and said that the call button should be in reach of the resident while she was in bed. LVN C said Resident had limited movement but was capable of using the call button to call for assistance. LVN C observed that the call button was hanging over the oxygen concentrator. LVN C said that the button was out of Resident #2's reach. LVN C said she did not know why the call button was left out of reach. LVN C said she did not know how long the call button had been out of Resident #2's reach and that Resident #2 would not have been able to place the call button on top of the oxygen concentrator on her own. LVN C said Resident #2 had not had any falls in her room. LVN C said there was a risk Resident #2 would not be able to call on facility staff and may not have her needs met.</p> <p>During an interview on 07/03/2024 at 3:21 p.m., the DON said the purpose of a call light was to contact staff for assistance. The DON said the call button should be in reach of residents while in bed. The DON said all facility staff are responsible to ensure the call button is within resident reach and should be monitored during routine rounds. The DON said there was a risk of the resident not being able to call for assistance.</p> <p>Review of facility policy titled Answering the Call Light, dated 2001, reads in part The purpose of this procedure is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45217</p> <p>Based on observation, interview and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 2 (Resident #2 and #3) of 6 residents reviewed for vehicle safety.</p> <p>-Maintenance Director failed to ensure Resident #2 and #3 were secured in the vehicle on 06/17/2024, while transporting residents back to the facility from dialysis visit, which resulted in falls with injuries.</p> <p>The noncompliance was identified as PNC. The IJ began on 06/17/2024 and ended on 06/18/2024. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk of accidents and potential harm.</p> <p>Findings include:</p> <p>Resident #2:</p> <p>Review of Resident #2's Face Sheet dated 07/10/2024, revealed a [AGE] year-old female, with an admitted [DATE]. Resident #2's diagnoses included: weakness, functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord), end stage renal diseases (ESRD) (condition in which the kidneys lose the ability to remove waste and balance fluids), neuromuscular dysfunction of bladder (nerves and muscles don't work together very well causing lack of bladder control), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), unsteadiness on feet, pain, and history of falling.</p> <p>Review of Resident #2's quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 10 indicating moderate cognitive impairment. Section on Functional Abilities and Goals revealed Resident #2 with impairment to one side of the upper and lower extremities. Resident was dependent on staff assistance for oral hygiene, toileting, bathing, dressing, personal hygiene, and transfers.</p> <p>Review of Resident #2's comprehensive care plan dated 07/10/2024, revealed the resident is at risk for falls with injury related to weakness. Part of the interventions included, Uses wheelchair for long distance mobility; fall precautions.</p> <p>Review of Resident #2's physician orders dated 07/10/2024, reads in part an order for dialysis: Hemodialysis (treatment to filter wastes and water from your blood) every Monday, Wednesday, and Friday with transport time to dialysis at 1:00 p.m.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's progress note dated 06/17/2024 at 7:03 p.m., written by LVN K reads while receiving oncoming report, this nurse received a phone call from facility driver that Resident #2 fell out of her chair onto the van floor while being transported back to the facility from dialysis. Driver unsure of any injury and called 911. The ambulance took resident to the hospital. An attempt to contact resident's RP was made with no success. Second RP was called and informed. Dr. and DON also notified.</p> <p>Review of Resident #2's progress note dated 06/18/2024 at 2:26 a.m., written by LVN K, reads (Resident #2) arrived back to the facility at 11:24 p.m., Her FM who was following the ambulance arrived approximately 5 minutes prior. She comes with a diagnosis of scalp hematoma (pool of mostly clotted blood that forms in an organ, tissue, or body space) and closed right fibula (outer and usually smaller of the two bones between the knee and the ankle in humans) fracture. A script for Tylenol 325 mg x 2 by mouth every 4 hours for fever and pain came with her. Upon assessment it was noted the hematoma to the back of her head, right side. No discoloration but pain to touch. She also has a cast on her right leg from her knee down to toes. When asked she stated a little pain to head. Tylenol given. It was effective.</p> <p>Review of Resident #2's progress noted dated 06/18/2024 at 12:07 p.m., written by SW, reads met with resident at bedside. FM also in room. SW inquired with resident about her recollection regarding the events that transpired the previous day. Resident verbalized not recalling what had occurred. SW inquired if she recalled being transferred and she stated she does not recall anything. SW asked if she was comfortable, and she verbalized she was. SW asked FM if he had any questions or concerns, and FM declined having any questions or concerns at the time. SW notified FM of on-going investigation. SW offered the number to the Complaint and Incident Intake number and Local Ombudsman and FM declined, stating he already had the information.</p> <p>Record review of EMS run record dated 06/17/2024 for Resident #2, reads R19 arrived with P24 already on scene to a 74 YOF who had suffered a fall from a sitting position. Patient was found lying supine on the floor of a transport van, alert and oriented, with (FM) present. Patient had stated that she had just finished her dialysis treatment and was being transported back home, when the van had taken a sharp left turn heading up [street name], and the patient fell out of her wheelchair and hit the back of her head on the floor of the van. Patient reported that she does not take any blood thinners or aspirin and that she did not lose consciousness. Patient was assisted by P24 and R19 crew members out of the van and onto the stretcher. Patient was placed onto R19 for further evaluation and treatment. Patient was placed on oxygen at 4LPM via nasal cannula, as reported she is on constant O2 and her SpO2 did drop to the high 80s when off oxygen. Patient was AO x4, a small bump to the back of her head was found, no bruising or bleeding present with no complaints of pain anywhere and vitals in normal range. Patient was transported code 1 to the hospital. Patient transfer was given to the hospital anursing staff and R19 departed the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of hospital records for Resident #2 dated 06/17/2024, reads Patient completed dialysis and was in the back of the van when the van took a hard turn and patient fell from wheelchair. There are no complaints from her, but scalp hematoma was found. Patient is here for evaluation. Lab results interpretation: CT scan of cervical spine without contrast with no acute findings in head or cervical spine. CT of brain without contrast with no acute findings in the head or cervical spine. Radiology of right tibia/fibula revealed, Distal (situated away from the center of the body or from the point of attachment) tibial (large bone at the front of the lower leg) fracture associated with proximal (situated nearer to the center of the body or the point of attachment) and distal fractures of the fibula (outer and usually smaller of the two bones between the knee and the ankle in humans). Severe generalized demineralization of bones.</p> <p>During an interview on 07/03/2024 at 11:01 a.m., Resident #2 said she did not remember what happened on 06/17/2024 while in the facility vehicle. Resident #2 does not remember any details of the incident including who was driving the vehicle, who else was in the vehicle, was she secured to the vehicle, where the incident occurred, or what happened after the incident.</p> <p>During an interview on 07/03/2024 at 11:05 a.m., Resident #2's RP and FM said on the day of the incident he was with Resident #2 during her dialysis visit. RP said the facility Maintenance Director arrived sometime around 5:30 p.m., to pick up Resident #2 and #3 to transport back to the facility. RP said he wheeled Resident #2 to the lift ramp of the vehicle and walked away to go to his truck. RP said he did not see how the driver secured the residents in the vehicle prior to departure. RP said he followed the facility vehicle. RP said that while at the intersection of two streets he observed the facility vehicle making a protected left turn and that it seemed that the vehicle was experiencing mechanical issues and the driver pulled over to park. RP said when he got off the truck to see if they needed assistance, he saw inside the van that both residents were on the floor. RP said he did not see any cars cutting off the van during the turn and from his perspective the van was not going fast. RP said when he walked up to the vehicle, he did not see any seatbelts on the residents and the residents had fallen to their right side. The RP said he observed the wheelchairs were upright. RP said Resident #2's head was leaning towards her right side and right leg was bent and left leg up on the armrest. The RP said Resident #3 was smaller than Resident #2 and he observed that Resident #3 was out of the wheelchair and lying on right side of head on floor. RP said the driver called 911 and emergency services showed up and assisted the residents to reposition, and then took both residents in ambulances. RP said the driver did not tell him anything about what happened. RP said Resident #2 had been transported in the vehicle regularly without any incident prior to the incident on 06/17/2024.</p> <p>Resident #3:</p> <p>Review of Resident #3's Face Sheet dated 07/03/2024, revealed a [AGE] year-old female, with an admitted [DATE]. Resident #3's diagnoses included: abnormalities of gait and mobility, end stage renal disease (condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis, anxiety disorder (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and lack of coordination.</p> <p>Review of Resident #3's quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 13 indicating she was intact cognitively. Section on Functional Abilities and Goals revealed Resident #3 was dependent on staff assistance for transfers and uses a manual wheelchair. Resident #3 had not had any other falls since admission.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's comprehensive care plan dated 07/03/2024, revealed the resident is at risk for falls. Part of the interventions included, Uses wheelchair for long distance mobility; fall precautions.</p> <p>Review of Resident #3's physician orders dated 07/10/2024, reads in part an order for dialysis: Hemodialysis three times a week with transport time to dialysis at 1:00 p.m.</p> <p>Review of Resident #3's progress note dated 06/17/2024 at 7:05 p.m., written by LVN L, reads Driver contacted facility to advise that residents were on their way back from dialysis and informed nurses that on a turn that resident fell and tipped over. Driver contacted 911, as there was a hematoma to patient's head. EMS on scene and resident to be transported to the hospital. FM has been notified as well as MD and DON.</p> <p>Review of Resident #3's progress note dated 06/18/2024 at 1:35 a.m., written by LVN L, reads Resident returned from the hospital at 12:30 a.m., Resident alert and currently voice no pain. Resident with facial bruising to left eye, abrasion to left leg. RN at hospital said CT scan done and clear with no abnormalities.</p> <p>Review of Resident #3's progress note dated 06/18/2024 at 12:04 p.m., written by the SW, reads Met with resident at bedside, family present. Female FM stepped out and male FM and resident remained in the room. SW inquired with resident about her recollection of the events that transpired the previous day. Resident reports she was being brought back home when a turn was made, and she tilted to the right side. SW inquired with resident if she had any other recollection and male FM interjected and stated she was not buckled in. SW asked male FM to allow resident to provide information. Resident then stated that she recalls driver doing something at the bottom of her wheelchair but states she was not buckled from the top. DON and Administrator notified.</p> <p>Record review of EMS run record dated 06/17/2024 for Resident #3, reads Rescue 25 found the patient lying prone inside of a van. Patient was a [AGE] year-old female complaining of pain to the right wrist and face. She sustained a hematoma to the left eyebrow as well as an abrasion to the left knee. Patient had completed dialysis and was on her way to facility. Patient states that she was a passenger inside of the van when the driver took a sharp turn and knocked the patient off of her seat onto the floor of the van. Patient was moved to the stretcher and loaded into rescue 25. Her vitals were assessed while en route to the hospital. Patient was transported to the hospital code one level three trauma. Patient was transferred over to hospital staff and rescue 25 left without incident.</p> <p>Record review of hospital records for Resident #3 dated 06/17/2024, reads Patient completed dialysis and was on the van. The van took hard turn and patient on wheelchair fell . Patient has facial bruises and complaining of left knee pain and right-hand pain. Pain level is 5/10 pain. Patient did not lose consciousness. Lab results interpretation: Radiology right hand with no definitive areas of acute bony injuries. Radiology of left tibia fibula with no acute bony injuries were demonstrated. Minimal degenerative changes left knee joint. CT scan of facial bones without contrast: impression left anterior frontal scalp hematoma and left periorbital (eyelid or skin around the eye) soft tissue swelling. No maxillofacial fracture. CT scan of brain without contrast: No acute intracranial hemorrhage.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/03/2024 at 9:58 a.m., DON said the Maintenance Director was a designated driver for the facility's only transportation vehicle. DON said the Maintenance Director would pick up residents who were out of the facility at appointments after 4:00 p.m. before the 6/17/2024 incident. DON said she received a call on 06/17/2024 around 6:00 p.m. from the Maintenance Director who had contacted 911 prior to calling the DON. DON said the Maintenance Director reported that he picked up Residents #2 and #3 from dialysis, and while traveling back to the facility, while he was turning the facility vehicle, a car was crossing, and he had to brake hard. The DON said Residents #2 and #3 were on their wheelchairs and fell out of their wheelchairs and onto the floor. DON said the Maintenance Director pulled over and called 911. DON said the residents were transported to the hospital by ambulance. DON said Resident #2 had a left distal tibial fracture. Resident #3 did not sustain any fracture but had scratches and bruises to her face. DON said the Maintenance Director returned to the facility without any passengers and left for the day. DON said she and the former Administrator conducted the investigation. DON said they interviewed the Maintenance Director, who said that he strapped the wheelchairs of the residents and secured them with the vehicle seatbelts. DON said Residents #2 and #3 were interviewed. DON said Resident #2 said she did not remember the incident and that she only remembers flying. DON said Resident #3 FM were very upset. DON said the SW interviewed Resident #3 and FM was present during the interview saying that she was not strapped in. DON said Resident #3 then agreed that she was not strapped in. DON said Maintenance Director was suspended two days and given written disciplinary action. DON said all drivers had to re-do driver competency with return demonstration. DON said there is one Facility Driver and three other designated drivers. DON said a decision was made that only the Facility Driver will drive residents to outside appointments, or they will call for an ambulance transportation.</p> <p>During an interview on 07/08/2024 at 10:13 a.m., Resident #3 said she was being picked up from dialysis by the Maintenance Director. Resident #3 said the Maintenance Director did not put a seatbelt on her. Resident #3 said it was only she, Resident #2, and the Maintenance Director in the vehicle. Resident #3 said while turning a corner she fell from her wheelchair to right side and hit her head. Resident #3 said she fell on her arm and had a bruise to her leg. Resident #3 said she told the driver that her arm was hurting, and he told her the ambulance was on the way. Resident #3 said she sustained facial injuries of a bump on her left eyebrow and bruises. Resident #3 said she did not remember if her wheelchair was secured or if it moved. Resident #3 said Resident #2 was behind her and fell as well.</p> <p>During an interview on 07/03/2024 at 12:10 p.m., Facility Driver said he was not present for the incident that occurred on 06/17/2024. Facility Driver said following the incident where residents had fallen, he is the only person who was authorized to drive the vehicle. He said that he had been the Facility Driver for several years and conducts training of other designated drivers. He said the former Administrator did not want him to work overtime and he would work until 2-2:30 p.m. He said that he arrives at work at 5:00 a.m., to drive residents to outside appointments. He said that the facility is now working on scheduling outside appointments within the time that he was scheduled to work, or he flexes his schedule to accommodate late evening appointments and pickups. He said that he inspected the vehicle on 06/18/2024 and found no mechanical issues with the equipment in the vehicle. He said that it was the neglect of the Maintenance Director who did not put the seatbelt on the residents. He said he trained the three other designated drivers and required that they performed a return demonstration around 3 months ago. He said that he had not experienced any issues with the securement devices while he had been driving.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 07/03/2024 at 12:20 p.m., Facility Driver was observed individually lifting three residents on the vehicle and securing each resident to go to an outside appointment. Facility Driver secured the frames of the wheelchairs with four-point anchors to the floor rail. He then secured residents by running a seatbelt across the residents and pulled each piece of equipment to ensure all belts and attachments were secured. There were no defects, or any other issues noted with vehicle equipment. Facility Driver found to be proficient at use of safety equipment.</p> <p>During an interview on 07/03/2024 at 2:00 p.m., the Maintenance Director said he had been in his position at the facility for two years. The Maintenance Director said he was a designated transporter up to 06/17/2024, in case of evacuations or emergencies. The Maintenance Director said he had been driving the facility vehicle for about a year without incident. The Maintenance Director said he was in-serviced on safe transportation by the Facility Driver back in July 2023. The Maintenance Director said the in-service covered the importance of buckling up residents, seatbelts, and putting on manual brakes. The Maintenance Director said he was trained to use floor anchors to secure the wheels and use the seatbelt that goes over the chest of passengers. He said there are two anchors used in front and two in the back that are attached to the frame of a wheelchair and adjusted to size. He said he was trained to double check to make sure the passenger was secured and there was no movement. The Maintenance Director said on 06/17/2024 during the evening he picked up Resident #2 and #3 from a dialysis appointment. He said he was driving about 30-40 MPH. He said that he waited at the intersection of two streets and waited for the protected left green light. He said that Resident #2's RP was following the vehicle. The Maintenance Director said the green light came on and he started turning left onto the farthest right lane of the three-lane road. He said he saw a white sedan facing the opposite direction that appeared to possibly turn into his lane. The Maintenance Director said he hit the brake and turned more left. He said he heard a hit on the floor and noticed that both Resident #2 and #3 fell to the right side. He said he stopped in the non-passing lane and called 911. He said that both wheelchairs were anchored to the floor. He said he could not explain what happened. He said he did not see any defects in the seatbelts or anchors. He said the seatbelts were off and he did not know if it was because of the hard braking. He said he was not in any rush to be anywhere. He said an ambulance arrived and they had to wait for a second ambulance. He said Resident #3 complained of pain to her arm and had a bump/bruise to her forehead. He said Resident #2's FM was present at the scene and that Resident #2 had landed on her back on the floor and had one of her legs stuck in the seatbelt. The Maintenance Director said after the residents were transported to the hospital he drove back to the facility. He said the following day the Facility Driver checked the van to make sure nothing snapped and re-in-serviced the Maintenance Director on properly securing passengers during transport having to do a return demonstration. The Maintenance Director said he then had to leave because he was suspended on 06/18/2024. He said he came back to the facility on [DATE] and had not driven the vehicle anymore.</p> <p>Review of vehicle manufacturer operation manual undated, reads in part, Safety belts must be worn by all occupants. Passengers can dramatically reduce their risk of being killed or seriously injured by wearing their safety belts. Organizations that own vans and wagons should have a written safety belt use policy. Drivers should be responsible for enforcing the policy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility provided Safe Transportation policy dated 05/2023, reads in part When transportation is the responsibility of the facility, staff will assist in transporting, handling, and transferring individuals. The purpose of this policy is to ensure the safety of individuals served as well as staff during transportation and include the provisions for handling emergency situations. Interpretation: 1. Vehicles must meet federal, state, local and manufacturer's safety and mechanical operating and maintenance standards for the vehicle. The Administrator and/or Director of Maintenance will ensure the safety of vehicles equipment, supplies, and materials owned or leased by the company and will maintain these in good condition during times of providing services. 5) Before allowing transportation staff to drive unsupervised, transportation staff must be trained and able to demonstrate the following: Operation of wheelchair lift, restraining devices and other special equipment; passenger assistance and securement; awareness and handling of unsafe conditions, emergencies, and security threats; and procedures for reporting abuse and neglect. 6) Transportation staff will receive training on each individual's transferring or handling requirements for the individual and/or equipment prior to transferring or transporting individuals. All transfers and handling of individuals served will be done in a manner that ensures safe transportation, dignity, and privacy. 12) In accordance with state laws, anyone riding in a moving vehicle must wear seatbelts and/or child safety restraints. To this end, every vehicle used to conduct facility business shall have a safety belt installed for each seating position. No vehicle shall be operated while carrying more passengers than available safety belts. Each motor vehicle operator and all occupants shall be secured with the safety belt or child safety seat whenever the motor vehicle is under power or in motion. The driver of the vehicle shall ensure that each occupant is properly restrained before beginning any trip, regardless of the length or duration, until the motor is shut off. Under no circumstances will any person be allowed to drive, ride, or otherwise be transported without such devices in use. 17) Residents using wheelchairs will be transported according to manufacturer's safety guidelines. This includes, but is not limited to, safe operation and regular maintenance of lift equipment, checks of straps to secure the wheelchair to the floor of the vehicle, and use of adaptive seating equipment when appropriate. Transportation staff who are transporting residents and who complete tie-downs of wheelchairs will receive training on how to do so and will be required to demonstrate competency prior to transporting individuals using wheelchairs.</p> <p>Review of employee records revealed Maintenance Director was hired on 09/28/2022. On 07/06/2023 the Maintenance Director received competency training on being a Van Driver-Transporter PRN. Maintenance Director was found to be competent in numerous tasks to include administrative functions which included reporting all incidents such as falls and change of condition to the DON immediately; personnel functions, transportation functions, staff development, safety and sanitation which included following established safety regulations in use of equipment; equipment and supply functions, and resident rights.</p> <p>The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering:</p> <p>On 6/18/2024 Facility Maintenance Director given disciplinary action of write up with two-day suspension.</p> <p>Review of employee timecard verified that employee was suspended 6/18/2024 and did not return to work until 6/24/2024.</p> <p>(continued on next page)</p>		

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  07/19/2024
NAME OF PROVIDER OR SUPPLIER  Regent Care Center of El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  10880 Edgemere Blvd El Paso, TX 79935	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/18/2024 Driver competencies were performed for one Facility Driver and three other staff members designated as drivers.</p> <p>On 6/18/2024 Facility restrictions put in place regarding who was able to drive residents on the vehicle allowing only the Facility Driver to drive residents.</p> <p>On 6/18/2024 Facility Driver verified functionality of seatbelt and safety straps finding no defects.</p> <p>On 6/18/2024 Facility in-service on teaching additional drivers properly how to strap residents on the wheelchairs to van when transporting.</p> <p>On 06/18/2024 Facility in-service on and abuse and neglect.</p> <p>After entry of investigator on 07/03/2024: Random sample residents (Resident #10, #12, #13, and #14) who had been transported by the facility vehicle were interviewed. Resident #10 was interviewed on 07/10/2024 at 8:59 a.m., Resident #12 as interviewed on 07/10/2024 at 8:54 a.m., Resident #13 was interviewed on 07/10/2024 at 9:02 a.m., and Resident #14 was interviewed on 07/10/2024 at 9:06 a.m. None of the residents reported any concerns with being secured when being transported in the vehicle. None of the residents reported any fall or near fall incidents in the vehicle.</p> <p>On 07/03/2024, observation made of Facility Driver performance on using securement safety devices in the vehicle. There was no evidence of any defects of safety equipment. Facility Driver found to be proficient at use of safety equipment.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</b></p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 4 (Resident #5, #9, #10, and #11) of 6 residents observed for oxygen management.</p> <p>-Resident #5, Resident #9, Resident #10, and Resident #11 were on oxygen and did not have oxygen signs posted outside their bedrooms.</p> <p>These failures could place visitors, staff, and others at risk of not knowing oxygen was being used in the room and to not smoke.</p> <p>Findings included:</p> <p>Resident #5:</p> <p>Review of Resident #5's face sheet dated 07/19/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses that included shortness of breath, chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), and emphysema (lung condition that causes shortness of breath).</p> <p>Review of Resident #5's initial MDS assessment dated [DATE], revealed Resident #5 had a BIMS score of 15 indicating she was intact cognitively. Section O - Special Treatments, Procedures, and Programs revealed Resident #5 was checked for oxygen therapy.</p> <p>Review of Resident #5's care plan dated 07/19/2024, revealed resident had potential for SOB due to COPD and emphysema and is receiving oxygen therapy. Part of the interventions included Administer oxygen therapy as ordered.</p> <p>Review of Resident #5's orders dated 07/19/2024, revealed an order to administer oxygen via nasal cannula or mask continuously for diagnosis of COPD every shift.</p> <p>During an observation and interview on 07/18/2024 at 11:15 a.m., Resident #5 was seated on a wheelchair in her bedroom. Observed resident with nasal cannula on. Resident #5 said she uses oxygen all day long. Observed there was no oxygen sign posted outside of her room.</p> <p>Resident #9:</p> <p>Review of Resident #9's face sheet dated 07/19/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (lungs cannot release enough oxygen into the blood, which prevents the organs from properly functioning).</p> <p>Review of Resident #9's quarterly MDS assessment dated [DATE], revealed Resident #9 had a BIMS score of 02 indicating severe cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed Resident #9 was checked for oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #9's care plan dated 07/19/2024, revealed resident was receiving oxygen therapy. Part of the interventions included Administer oxygen therapy as ordered.</p> <p>Review of Resident #9's orders dated 07/19/2024, revealed an order to administer oxygen at 2 liters per minute via nasal cannula or mask continuously every shift.</p> <p>During an observation on 07/18/2024 at 10:55 a.m., Resident #9 was observed lying on his bed asleep with nasal cannula on and oxygen machine running. Observed there was no oxygen sign posted outside of his room.</p> <p>Resident #10:</p> <p>Review of Resident #10's face sheet dated 07/19/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of Resident #10's annual MDS assessment dated [DATE], revealed Resident #10 had a BIMS score of 03 indicating severe cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed Resident #10 was checked for oxygen therapy.</p> <p>Review of Resident #10's care plan dated 07/19/2024, revealed resident was receiving oxygen therapy. Part of the interventions included Administer oxygen therapy as ordered.</p> <p>Review of Resident #10s orders dated 07/19/2024, revealed an order to administer oxygen PRN to keep O2 saturations above 90%.</p> <p>During an observation on 07/18/2024 at 11:00 a.m., Resident #10 room observed with oxygen concentrator inside his room. There was no oxygen sign posted outside of his room.</p> <p>Resident #11:</p> <p>Review of Resident #11's face sheet dated 07/19/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses that included chronic cough.</p> <p>Review of Resident #11's initial MDS assessment dated [DATE], revealed Resident #11 had a BIMS score of 15 indicating she was intact cognitively. Section O - Special Treatments, Procedures, and Programs revealed Resident #11was checked for oxygen therapy.</p> <p>Review of Resident #11's care plan dated 07/19/2024, revealed resident had potential for SOB due to pneumonia and bronchiectasis (a condition in which the lungs' airways become damaged, making it hard to clear mucus) and is receiving oxygen therapy. Part of the interventions included Administer oxygen therapy as ordered.</p> <p>Review of Resident #11's orders dated 07/19/2024, revealed an order to administer oxygen at 4 liters per minute via nasal cannula or mask continuously for diagnosis of pneumonia every shift.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 7/18/2024 at 11:06 a.m., Resident #11 was observed sitting on a wheelchair in her bedroom wearing a nasal cannula with the oxygen concentrator running. Resident #11 said she always uses oxygen via cannula or mask. Observed there was no oxygen sign posted outside of her room.</p> <p>During an interview on 07/18/2024 at 11:13 a.m., RN D said all residents who are on oxygen therapy should have a sign outside of their room doors that read oxygen in use. RN D said the purpose of the signs are to make visitors, staff, and anyone else aware of oxygen in use and to not smoke. RN D said the facility is smoke free, but the signs should still be posted.</p> <p>During an interview on 07/19/2024 at 3:00 p.m., the DON said that residents on oxygen require an oxygen sign posted outside of the resident's room. The DON said the purpose was to let visitors and anyone at the facility know that oxygen was being used in the room. The DON said the facility was a non-smoking facility making the risk smoking incidents very low. The DON said the charge nurse in the hall was responsible for ensuring the oxygen signs were posted.</p> <p>Review of facility provided Oxygen Administration policy dated July 2019, reads in part The purpose of this procedure is to provide guidelines for safe oxygen administration. The following equipment and supplies will be necessary when performing this procedure (oxygen therapy): No smoking/Oxygen in Use signs. Steps in the Procedure included the following: Place an Oxygen in Use sign on the outside of the room entrance door.</p>		