| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675831 | A. Building<br>B. Wing | 09/20/2024 |

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

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871<br><br>Based on interview and record review the facility failed to implement written policies that prohibit and prevent abuse for 1 (Resident #7) of 8 residents reviewed for abuse.<br><br>The facility failed to implement their abuse policy when they failed to immediately suspend CNA B after Resident #7's RP reported a physical restraint allegation.<br><br>This failure could place residents at risk of potential continued mistreatment and abuse.<br><br>Findings included:<br><br>Record review of Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy dated April 2021 read in part Investigating Allegations: 6- any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.<br><br>Record review of Resident #7's face sheet dated 9/18/24 revealed a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of anxiety and dementia.<br><br>Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, indicating she was severely cognitively impaired and was dependent for toileting.<br><br>Record review of Resident #7's care plan dated 06/01/24 revealed focus area for Resident #7 is refusing care, including brief changes; is having physically aggressive behavior with interventions that included Talk in calm voice when care is refused; Report care refusal to RP and MD; Monitor for any skin impairment; Do not argue with resident; Talk in calm voice when behavior is disruptive; Refer to Social Services for evaluation; Reinforce unacceptability of verbal abuse; Remove from public area when behavior is disruptive and unacceptable; Monitor and document target behaviors; Assist in selection of appropriate coping mechanisms; Requires 2 staff members in room at all times; Administer behavior medications as ordered by physician.<br><br>Record review of Resident #7's grievance dated 07/31/24, written by the SW, revealed RP reports CNA B physically restrained<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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #7 while changing her. RP did not witness but was outside bathroom while 3 CNAs were inside changing Resident #7. RP stated it was the male CNA. The DON was contacted on 07/31/24. Summary/ Findings revealed CNA B stated she (Resident #7) hit one of her arms against the wall but didn't see any bruising at the moment and the 3 CNAs assisted with the toilet transfer. Statement from CNAs (CNA A, CNA B and CNA C) were gathered, abuse and neglect in-services signed by staff. situation was reported to SO . The grievance was marked as resolved as of 08/01/24 with interventions that included CNA B removed from Resident #7's care and RP was contacted with investigation results.<br><br>Record review of CNA B's timecard revealed he worked the following days and hours after the allegation was received on 07/31/24: 07/31/24 from 2:50 pm- 9:56 pm; 08/01/24 from 9:25 pm- 11:38 pm.<br><br>During an attempted interview on 09/18/24 at 1:14 pm, a call was placed to CNA C with no answer and was unable to leave a VM to return call.<br><br>During an interview on 09/18/24 at 1:42 pm, CNA A stated she was familiar with Resident #7 and she required 2 person assist with toileting and was advised to always provide care with 2 persons for witnesses to care provided. CNA A stated her, and CNA C were asked by Resident #7's RP to change her brief on 07/28/24 . CNA A stated when CNA C arrived to Resident #7 to assist with the toilet transfer, Resident #7's RP excused herself from the room. CNA A stated herself and CNA C were at Resident #7's sides and CNA B was in front of her to assist with the toilet transfer. CNA A stated when CNA C placed the gait belt on Resident #7 and asked her to stand up, Resident #7 started swinging her hands attempting to hit them. CNA A stated Resident #7 was left alone to calm down and when she calmed down, CNA C attempted to assist with transfer again and Resident #7 complied with no issues. CNA A stated CNA C then excused himself and herself CNA A stayed with Resident #7. CNA A stated she did not notice any bruising to Resident #7 and denied any physical restraints used. CNA A stated she was asked to write a statement a few days later due to the allegation that was made and was not suspended.<br><br>During an interview on 09/19/24 at 11:05 am, Resident #7 was greeted, and she did not acknowledge Surveyor.<br><br>During an interview on 09/19/24 at 2:55 pm, the DON stated she had been notified of the allegation by SW on 07/31/24 but could not remenber at what time the allegation had been initially report. The DON stated she initiated her investigation and had followed up with Resident #7's RP who denied witnessing the toilet transfer and only stated the bruises had been a result of the transfer. The DON stated she finished the investigation at the time the incident was submitted, on 08/06/2024 at 4:51pm. The DON stated Resident #7's RP did not think it was due to being aggressive only that it occurred because of the transfer. The DON stated she interviewed CNA A, CNA B, and CNA C who denied the physical restraint allegation and all 3 had witnessed the toilet transfer. The DON stated they all stated Resident #7 had become combative during the toilet transfer and denied noticing any bruising at the moment. The DON stated she had not suspended the alleged APs due to all 3 witnessing the incident. The DON stated she finished her investigation on 08/01/24. The DON stated per their abuse policy the CNAs should have been suspended until the investigation was completed. The DON stated the failure to suspend CNA A, CNA B, and CNA C could have placed residents at risk for possible continued abuse. The DON stated she had not received any complaints related to abuse against the 3 CNAs and stated SW had conducted safety surveys with random residents in that hallway with no findings.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/19/24 at 3:26 pm, CNA B stated he was familiar with Resident #7 care and she required 2 person assist with toileting and also required 2 person care provided due to the combative behavior and the RP's accusatory behavior. CNA B stated he had been asked by one of the CNAs to assist with the toilet transfer on 07/28/24. CNA B stated when he arrived to Resident #7's room the RP excused herself and left the room. CNA B stated in the restroom the other CNAs (CNA A and CNA C) were at her side and he was facing her. CNA B stated when he placed the gait belt on Resident #7, she started swinging her arms around and had hit the wall and the sink. CNA B stated they backed away to allow her to calm down. CNA B stated she calmed down and asked her to assist to a standing position to get her on the toilet and she complied. CNA B stated he then left the restroom and the CNAs stayed with her. CNA B stated when he got out of the restroom the RP was outside and apologized on Resident #7's behalf and stated I know how she gets. CNA B stated a few days later he was questioned and was surprised due to RP not mentioning anything that day he assisted with the toilet transfer. CNA B denied the allegation and stated he was not suspended.<br><br>During an interview on 09/20/24 at 3:12 pm, the Administrator stated it was her first week working at the facility and had not known about the self-reports pending . The Administrator stated based on the abuse policy it would have been expected for the APs to be suspended until the investigation was completed regardless of the many witnesses present at the time of the allegation. the Administrator stated failure to suspend the APs after an allegation made placed residents at risk for possible continued abuse. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871<br><br>Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 2 (Resident #4 and Resident #7) of 8 residents reviewed for care plans.<br><br>The facility failed to develop a comprehensive person-centered care plan for Resident #4 who required mechanical lift transfer.<br><br>The facility failed to develop a comprehensive person-centered care plan for Resident #7 who no longer required a Hoyer lift transfer and was a 2 person assist transfer.<br><br>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and not having personalized plans developed to address their needs.<br><br>Findings included:<br><br>Record review of Resident #4's face sheet dated 09/18/24 revealed an [AGE] year old female who was readmitted to the facility on [DATE] with diagnoses of muscle weakness, dementia, and other abnormalities of gait and mobility.<br><br>Record review of Resident #4's history and physical dated 08/21/24 revealed [AGE] year-old female coming back from local hospital after being treated for bradycardia (slow heart rate), hypotension (low blood pressure), and right/ankle fracture.<br><br>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03, which indicated her cognition was severely impaired and required assistance with transfers.<br><br>Record review of Resident #4's care plan dated 08/20/24 revealed focus area for requires assistance for all ADL 's, because of risk of syncope collapse with interventions of Encourage to complete ADL tasks as independently as possible. There was no care plan for use of mechanical life for transfers.<br><br>During an observation and interview on 09/19/24 at 11:14 am, Resident #4 stated she was transferred with the machine now and denied any concerns with care provided. Lead CNA and CNA E both assisted Resident #4 from her wheelchair to bed using the mechanical lift. Lead CNA and CNA E stated Resident #4 required a mechanical lift transfer with 2 person assist and stated the charge nurse had reported the changes to her transfer needs when she arrived from her more recent hospitalization sometime in August.<br><br>Record review of Resident #7's face sheet dated 9/18/24 revealed a [AGE] year-old female was readmitted to the facility on [DATE] with diagnoses of anxiety and dementia.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, which indicated she was severely cognitively impaired and was dependent for transfers.<br><br>Record review of Resident #7's care plan last reviewed on 06/01/24 revealed focus area for total dependence with transfers. Uses Hoyer lift with interventions of Use Hoyer lift as indicated and Monitor for signs/symptoms pain.<br><br>During an interview on 09/19/24 at 9:42 am, PT stated Resident #7 did not require a Hoyer lift for transfer. PT stated Resident #7 at one point required mechanical lift transfer due to a fracture but since she had recovered good with no complications, Resident #7 had been doing well with 2-person transfer. PT stated Resident #4 had a recent fracture to her ankle, and when she returned from the hospital, she required a Hoyer lift transfer. PT stated Resident #4 required 1 person assistance prior to the fracture and had done well with assisting during the transfers.<br><br>During an observation and interview on 09/19/24 at 11:05 am, Resident #7 ignored Surveyor and Lead CNA and CNA D assisted Resident #7 from her wheelchair to bed. A 2 person assist transfer was provided, with no concerns noted. Lead CNA and CNA D stated Resident #7 had been a 2 person assist for several months now and the charge nurses were good about reporting any changes to resident's care.<br><br>During an interview on 09/20/24 at 1:26 pm, DON stated the MDS nurses were responsible for reviewing and updating care plans quarterly, annually, and as needed. The DON stated she was responsible for overlooking the care plans since they required her signature to complete the comprehensive care plans. The DON stated Resident #7 currently required 2 person assist for transfers and Resident #4 required mechanical lift transfer. The DON stated there were no risks for Resident #4's and Resident #7's care plans not reflecting current care needed for transfers due to charge nurse and CNAs good communication related to any changes. The DON stated she may have overlooked Resident #7's and Resident #4's care plans.<br><br>During an interview on 09/20/24 at 2:29 pm, MDS Nurse stated she was responsible for Resident #7's care plan and stated she was aware she required 2-person transfer. MDS Nurse stated she reviewed and revised care plans quarterly, annually, and as needed. MDS Nurse stated she may have overlooked Resident #7's transfer need change. MDS Nurse stated there were no risks due to the charge nurses reporting any changes to the CNAs. MDS Nurse stated she was not responsible for Resident #4's care plan due to when she returned from the hospital, she was considered skilled nursing and would belong to the other MDS Nurse. MDS Nurse stated Resident #4's care plan did not have mechanical lift transfer and should have been initiated. MDS Nurse stated there could be a risk for Resident #4's and Resident #7's care plans not being accurate due to lack of monitoring if CNAs did not provide proper transfer.<br><br>During an interview on 09/20/24 at 3:12 pm, the Administrator stated comprehensive care plans were reviewed and revised by the MDS Nurse quarterly, annually and as needed. The Administrator stated transfers should be accurate to reflect the care they currently received. The Administrator stated there was potential risk for injury if CNAs did not provide proper transfer.<br><br>Record review of Care Plans- Comprehensive policy not dated read in part each residents comprehensive care plan is designed to: E- reflect treatment goals, timetables and objectives in measurable times; G- aid in preventing or reducing declines in the resident's functional status and/or functional levels |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871<br><br>Based on observation, interview and record review the facility failed to ensure that residents environment remained as free of accidents and hazards as possible and each resident received adequate supervision to prevent accidents for 1 (Resident #4 ) of 8 residents reviewed for transfers.<br><br>The facility failed to ensure Lead CNA placed breaks on the mechanical lift when lifting Resident #4 from her wheelchair and lowering to her bed.<br><br>This failure could place residents at risk for falls or injuries.<br><br>Findings included:<br><br>Record review of Resident #4's face sheet dated 09/18/24 revealed an [AGE] year old female who was readmitted to the facility on [DATE] with diagnoses of muscle weakness, dementia, and other abnormalities of gait and mobility.<br><br>Record review of Resident #4's history and physical dated 08/21/24 revealed [AGE] year-old female coming back from local hospital after being treated for bradycardia (slow heart rate), hypotension (low blood pressure), and right/ankle fracture.<br><br>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03, which indicated her cognition was severely impaired and required assistance with transfers.<br><br>Record review of Resident #4's care plan dated 08/20/24 revealed focus area for requires assistance for all ADL's, because of risk of syncope collapse with interventions of Encourage to complete ADL tasks as independently as possible. There was no care plan for use of Hoyer for transfers.<br><br>During an observation and interview on 09/19/24 at 11:14 am, Resident #4 stated she was transferred with the machine now and denied any concerns with care provided. Lead CNA and CNA E both assisted Resident #4 from her wheelchair to bed using the mechanical lift. Lead CNA checked the mechanical lift functionality and maneuvered the mechanical lift. CNA E was at Resident #4's side providing assistance by holding the sling by her head. Lead CNA placed the mechanical lift in front of Resident #4 and assisted with latching the sling on the Hoyer lift. Lead CNA only placed one brake on the right side and lifted Resident #4 up, brake was released and maneuvered over to the bed. Lead CNA lowered Resident #4 to her bed, no brakes were placed.<br><br>During an interview on 09/19/24 at 11:20 am, CNA E stated she had received training upon hire regarding mechanical left transfer and was trained to place brakes when lowering and lifting residents. CNA E stated failure to not place brakes when lowering and lifting residents could result in injury and/or fall if the mechanical lift tipped and fell over.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/20/24 at 1:26 pm, ADON and DON stated CNAs received training upon hire and at least quarterly regarding mechanical lift transfers. ADON and DON stated brakes were required to be placed when lowering and lifting residents. ADON and DON stated brakes were placed to prevent the mechanical tipping over and resulting in possible injury/falls. ADON and DON stated the brakes should have been placed when lowering and lifting Resident #4 and Lead CNA was responsible for overseeing proper transfers.<br><br>During an interview on 09/20/24 at 2:12 pm, Lead CNA stated she was responsible for overseeing proper transfers at random and had not had any concerns. Lead CNA stated she had become nervous and forgot to place brakes when lowering and lifting Resident #4 and could have placed her at risk for possible fall with injury. Lead CNA stated she had received training on mechanical lift transfer upon hire and quarterly.<br><br>During an interview on 09/20/24 at 3:12 pm, the Administrator referred mechanical transfer to DON.<br><br>Record review of Lifting Machine, Using a Portable not dated did not specify when to use brakes on the Hoyer lift. |