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	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemere Estates	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse for 1 (Residents #4) of 4 residents reviewed for abuse. The facility failed to ensure residents were free from physical abuse when Resident #2 wandered into another resident's room, punched Resident #4 on the arm, attempted to hit and started cursing when Resident #4 told Resident #2 that he was in the wrong room. This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included:Resident #4Record review of Resident #4's Closed Records reflected an admission Record admission Date 11/24/25. Resident was discharged [DATE]. Review of History and Physical dated 12/02/25 for Resident #4 revealed [AGE] year-old female with past medical history of CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), Diabetes Mellitus (a chronic condition where the body does not produce enough insulin or cannot use insulin effectively), HTN (when the force of blood pushing against the artery wall is consistently too high, making the heart work harder and straining blood vessels, which increases the risk of heart attack and stroke), Hypothyroidism - thyroid gland does not produce enough thyroid hormones, which control body's energy use causing many functions to slow down leading to fatigue, weight gain, feeling cold, and dry skin). Review of admission MDS dated [DATE] for Resident #4 revealed, clear speech, makes self-understood, understands others, BIMS Score 13 (cognitively intact). Independent with indoor mobility with walker. Review of Care Plan dated 12/05/25 for Resident #4 revealed, Resident to Resident altercation. Resident struck by another resident while in room. Aggressor removed immediately. No visible injuries. Interventions: Provide emotional reassurance and maintain therapeutic communication. Review of Progress Note dated 12/05/25 for Resident #4 written by Nurse Practitioner revealed, today patient has been seen and evaluated with the charge nurse in charge of the patient. During today's rounds, patient was heard calling out for help. Upon entering room, it was observed that another resident had entered her room unintentionally. The resident appeared confused and was reportedly looking for his own room. The patient stated that the other resident hit her in the left arm and attempted to kick her. Patient described feeling startled by the encounter. A full evaluation was conducted at bedside, alert oriented to person, place, and time. Upon physical exam left arm, now swelling, no redness, no bruising, no tenderness on palpation, full ROM without pain, no visible signs and symptoms of trauma or injury. Distress Assessment: Patient verbalized she was OK and denied ongoing pain or discomfort. She stated that she was primary startled by the incident. Record review of Resident #2's Closed Records reflected an admission Record with the Original admission Date as 02/16/2023 and re-admission Date as 02/10/25. Resident was discharged [DATE].Review of Hospital paperwork from Geriatric Behavioral Unit (GBU) dated 12/05/25 for Resident #2 reflected, admission date 12/05/25 and discharge date [DATE]. History & Physical dated 12/05/25 revealed [AGE] year-old male transferred to Geriatric Behavioral Units from the ER, brought in via EMS, from nursing home for violent behavior and GBU evaluation. Reason for admission: danger to others, danger deterioration. History and Present Illness: According to ED notes: He was recently discharged on 12/01/25 after being admitted on [DATE] for similar reasons of aggression with staff and residents at the nursing facility. This is his 3rd admission this year, the first one in February of this year. Patient was confused, does not acknowledge behaviors that brought him here. Denies mood swings, hallucinations. The patient is unable to answer questions. Review of systems: no anxiety, no depression. Summary Statement and Safety Plan: Due to these chronic acute, protective factors, I do find this individual to be at a high risk of hurting themselves or others. Will remain in structured environment. On-going psychiatric assessment and close monitoring. Maintain inpatient care to ensure patient safety and stabilization. Record review of Resident #2's History & Physical dated 04/03/25 revealed [AGE] year-old male with past medical history of vascular dementia with mood disturbance (A condition where brain damage from poor blood flow causes issues with thinking and memory, along with significant emotional changes like depression, anxiety and extreme mood swings), recurrent depressive disorder (Repeated episodes of feeling deeply sad, lost interest in things, have no energy and experience other symptoms like sleep, appetite changes, and might have periods of normal moments in between the episodes before the next depressive episode comes back), generalized anxiety disorder (constantly feel anxious or on edge about everyday things. Even when there's little reason to and it's hard to turn now or control, leading to physical symptoms like muscle tension, fatigue and trouble sleeping

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) residents (Resident #2) reviewed for dementia care. -The facility failed to provide or address the customary routines, preferences, and choices to enhance Resident #2's well-being when he refused care, refused labs, and became physically and verbally aggressive from August 2025 - December 2025. -The facility failed to implement interventions related to behavioral issues related to dementia, when Resident #2 wandered into another resident's room, punched Resident #4 on the arm, attempted to strike and was cursing when Resident #4 told Resident #2 that he was in the wrong room. This failure could result in residents with dementia not receiving services focused on their dementia-related behaviors which placed him and other residents at risk of not receiving the necessary personal care and services and placed residents at risk of verbal and physical abuse related to wandering behavior. Findings included: Resident #4Record review of Resident #4's Closed Records reflected an admission Record admission Date 11/24/25. Resident was discharged [DATE]. Review of History and Physical dated 12/02/25 for Resident #4 revealed [AGE] year-old female with past medical history of CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), Diabetes Mellitus (a chronic condition where the body does not produce enough insulin or cannot use insulin effectively), HTN (when the force of blood pushing against the artery wall is consistently too high, making the heart work harder and straining blood vessels, which increases the risk of heart attack and stroke), Hypothyroidism - thyroid gland does not produce enough thyroid hormones, which control body's energy use causing many functions to slow down leading to fatigue, weight gain, feeling cold, and dry skin). Review of admission MDS dated [DATE] for Resident #4 revealed, clear speech, makes self-understood, understands others, BIMS Score 13 (cognitively intact). Independent with indoor mobility with walker. Review of Care Plan dated 12/05/25 for Resident #4 revealed, Resident to Resident altercation. Resident struck by another resident while in room. Aggressor removed immediately. No visible injuries. Interventions: Provide emotional reassurance and maintain therapeutic communication. Review of Progress Note dated 12/05/25 for Resident #4 written by Nurse Practitioner revealed, today patient has been seen and evaluated with the charge nurse in charge of the patient. During today's rounds, patient was heard calling out for help. Upon entering room, it was observed that another resident had entered her room unintentionally. The resident appeared confused and was reportedly looking for his own room. The patient stated that the other resident hit her in the left arm and attempted to kick her. Patient described feeling startled by the encounter. A full evaluation was conducted at bedside, alert oriented to person, place, and time. Upon physical exam left arm, now swelling, no redness, no bruising, no tenderness on palpation, full ROM without pain, no visible signs and symptoms of trauma or injury. Distress Assessment: Patient verbalized she was OK and denied ongoing pain or discomfort. She stated that she was primary startled by the incident. Record review of Resident #2's Closed Records reflected an admission Record with the Original admission Date as 02/16/2023 and re-admission Date as 02/10/25. Resident was discharged [DATE].Review of PASRR Level 1 Screening dated 12/01/2025 for Resident #2 revealed, Primary Diagnosis of Dementia, Mental Illness. Review of Hospital paperwork from Geriatric Behavioral Unit (GBU) dated 12/05/25 for Resident #2 reflected, admission date 12/05/25 and discharge date [DATE]. History & Physical dated 12/05/25 revealed [AGE] year-old male transferred to Geriatric Behavioral Units from the ER, brought in via EMS, from nursing home for violent behavior and GBU evaluation. Reason for admission: danger to others, danger deterioration. History and Present Illness: According to ED notes: He was recently discharged on 12/01/25 after being admitted on [DATE] for similar reasons of aggression with staff and residents at the nursing facility. This is his 3rd admission this year, the first one in February of this year. Patient was confused, does not acknowledge behaviors that brought him here. Denies mood swings, hallucinations. The patient is unable to answer questions. Review of systems: no anxiety, no depression. Summary Statement and Safety Plan: Due to these chronic acute, protective factors, I do find this individual to be at a high risk of hurting themselves or others. Will remain in structured environment. On-going psychiatric assessment and close monitoring. Maintain inpatient care to ensure patient safety and stabilization. Record review of Resident #2's History & Physical dated 04/03/25 revealed [AGE] year-old male with past medical history of vascular dementia with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, to include adequate monitoring for 1 (Resident #2) of 4 residents reviewed for unnecessary medications. The facility failed to ensure Resident #2 had behavior monitoring documentation on the Treatment Administration for his prescribed Valproic Acid (an antipsychotic medication), Hydroxyzine (an antianxiety/anticholinergic medication used to treat anxiety) and Trazodone HCL (used to treat insomnia). This failure could put residents at risk of harm from adverse reactions or harmful side effects. Findings included:Closed Record review of Resident #2's admission Record revealed Original admission Date 02/16/2023 and re-admission Date 02/10/25. -Review of Hospital paperwork from Geriatric Behavioral Unit dated 12/05/25 for Resident #2 revealed, admission date 12/05/25 and discharge date [DATE]. History & Physical dated 12/05/25 revealed [AGE] year-old male transferred to Geriatric Behavioral Units from the ER, brought in via EMS, from nursing home for violent behavior and GBU evaluation. Reason for admission: danger to others, danger deterioration. History and Present Illness: According to ED notes: He was recently discharged on 12/01/25 after being admitted on [DATE] for similar reasons of aggression with staff and residents at the nursing facility. This is his 3rd admission this year, the first one in February of this year. Patient was confused, does not acknowledge behaviors that brought him here. Denies mood swings, hallucinations. The patient is unable to answer questions. Review of systems: no anxiety, no depression. Summary Statement and Safety Plan: Due to these chronic acute, protective factors, I do find this individual to be at a high risk of hurting themselves or others. Will remain in structured environment. On-going psychiatric assessment and close monitoring. Maintain inpatient care to ensure patient safety and stabilization. Estimated length of stay: 5 to 10 days. Record review of Resident #2's History & Physical dated 04/03/25 revealed [AGE] year-old male with past medical history of vascular dementia with mood disturbance (A condition where brain damage from poor blood flow causes issues with thinking and memory, along with significant emotional changes like depression, anxiety and extreme mood swings), recurrent depressive disorder (Repeated episodes of feeling deeply sad, lost interest in things, have no energy and experience other symptoms like sleep, appetite changes, and might have periods of normal moments in between the episodes before the next depressive episode comes back), generalized anxiety disorder (constantly feel anxious or on edge about everyday things. Even when there's little reason to and it's hard to turn now or control, leading to physical symptoms like muscle tension, fatigue and trouble sleeping, making daily life feel overwhelming), and impulse disorder (A struggle to stop one's self from doing things, you shouldn't, leading to sudden actions like anger outburst, stealing or binge eating, even when they cause problems to the individual or others). History of falls, status post intertrochanteric fracture of left femur (A break in the upper part of the thigh bone, right where it connects to the hip).Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed BIMS Score 3 (severe cognitive impairment), functional limitation in range of motion to upper and lower extremities, Mobility device - wheelchair; requires substantial/maximal assistance with toileting hygiene, lower body dressing and putting on/taking off footwear; dependent with showers; partial/moderate assistance with personal hygiene. Set up assistance with sit to lying, sit to stand, chair/bed transfer, and tub/shower transfer and once seated in wheelchair, the ability to wheel at least 150 feet in a corridor or similar space. Active Diagnoses: Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life), anxiety, depression, vascular dementia with mood disturbance and recurrent depressive disorder. High-Risk Drug Use - antidepressant, and anticonvulsant. Record review of Resident #2's Care Plan revealed: -Care Plan revised on 12/05/25 reflected Resident #2 has potential to be physically aggressive, related to dementia and poor impulse control. Interventions: In service direct care staff on residence behaviors and how to detect escalation. Analyzed times of day, places, circumstances, triggers and what the escalates behavior and document. Administer medications and labs as ordered. Monitor for side effects and effectiveness and notify physician of effectiveness. Assess and address for contributing sensory triggers as they occur. The residence triggers for physical aggression are to be monitored and identified so they can be used to deescalate the situation. When the resident becomes agitated, intervene before agitation escalates.-Review of Physician Order Summary Dated 12/15/25 for Resident #2 revealed, Anti-Depressant SE Monitoring: Order Start Date: 12/01/25 Observe closely for significant side effects of Anti-Depressant medication including drowsiness

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review, the facility failed to ensure 4 of 11(LVN E, CNA L, CNA G, and Activities Director) employees whose in-service records were reviewed had not received the required minimum 1-hour annual in-service training for Dementia and Behavior Management. The facility failed to keep copies of documentation of the required annual Dementia and Behavior Management training for LVN E, CNA L, CNA G, and Activities Director before the change of ownership was completed on December 04, 2025. This failure placed residents at risk for unmet needs due to untrained staff. Findings included: During an interview and Record Review on 12/16/25 at 4:42 PM with HR Payroll Coordinator revealed they had a change of ownership on December 04, 2025, and she no longer had access to training records from the previous company to show Dementia/Behavior/Communication training was completed on an annual basis according to facility policies for the following employees. -LVN Charge Nurse E was hired on 05/18/25. Documentation revealed Dementia/Behavior/Communication training was completed on 04/07/25. No previous training records were available to review due to change of ownership. -CNA L was hired on 10/27/23. Documentation revealed Dementia/Behavior/Communication training was completed on 09/25/25. No previous training records were available to review due to change of ownership. -CNA G was hired on 05/31/24. Documentation revealed Dementia/Behavior/Communication training was completed on 08/05/25. -Activities Director was hired on 09/25/19. Documentation revealed Dementia/Behavior/Communication training was completed on 08/05/25. No previous training records were available to review due to change of ownership. -During an interview on 12/15/25 at 4:00 PM, revealed he was trained this year but could not recall what date he had completed the computer training on Dementia/Behavior/Communication. - During an interview on 12/16/25 at 1:30 PM revealed, she did not recall if she had received training on Dementia/Behavior/Communication. -During an interview on 12/16/25 at 2:27 PM with the Executive Director revealed they had a change of ownership on 12/04/25. He said, So everyone was considered to be a new hire. He said they had not made copies of training records for the facility staff prior to the change of ownership and did not have documentation of the last annual training on Dementia and Behavior Management for some of the staff. He said, Like I said all the staff are considered to be new hires due to change in ownership and we are in the process of completing the annual training on Dementia and Behavioral Management. Review of facility's Policy and Procedure on Dementia Care implemented 11/2017 revealed, Policy: It is a policy of this facility to provide the appropriate treatment and services to every resident who display signs of or is diagnosed with dementia to meet his or her highest practical, physical, mental and psychological well-being. Explanation and Compliance Guidelines. The care plan interventions will be related to each residence individual symptomology and rate of dementia (or related diseases) progression with end result being noted improvement or maintain of the expected stable rate were decline associated with dementia and dementia like illnesses. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. If needed, the environment will be modified to accommodate individual resident care needs. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. All staff will be trained in dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies, and skill sets to ensure resident's safety and help residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.