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Form Approved OMB
No. 0938-0391

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 34486 43871 Based on observation, interview, and record review, the facility failed to post in a form and manner accessible to residents, resident representatives contact information including telephone numbers for Long Term Care Ombudsman program for residents interviewed in a confidential group meeting. The facility failed to ensure the Ombudsman program information was posted in an area accessible for residents who required the use of wheelchair. This failure placed residents at risk of not being informed about the Ombudsman Program. Findings included: During a confidential group meeting on 3/12/24 at 9:30 am, residents who were wheelchair bound stated they did not know where to find the local Ombudsman information. During an observation and interview on 3/14/24 at 11:08 am, the Administrator stated the Ombudsman number was posted in the 100 hallway. The Administrator stated the Ombudsman number posting may have been too high for residents in wheelchairs to see. The Administrator stated he would move it down and stated the posting had been there for years and had not received complaints in the past. Record review of Displaying of Required Notices and Signage (not dated) read in part the facility will display required state and federal notices and signage that affect or concern employees, residents and/or visitors. The policy did not address ready accessible to wheelchair bound resident.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34486 Based on observation, interview and record review the facility failed to ensure that residents had the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and were posted in a place readily accessible to residents, and family members and legal representatives of residents for residents interviewed in a confidential group meeting. The facility failed to have the survey manual readily accessible for the residents to view the survey. This failure could place residents at risk of not being able to fully exercise their rights to be informed of the facility's survey history. Findings included: During a confidential group meeting on 3/12/24 at 9:30 am, residents stated they did not know where or how to access the survey results in the facility. During an observation on 03/13/24 at 9:00 am, survey results were in the lobby area. Survey results signs were posted in hallways near the nurse's station where it said it was in nurses' station and lobby area. A Code was needed to get out of the nurse's station to get to the lobby area. During an observation and interview on 03/13/24 at 9:01 am, LVN B stated that the survey binder was in the lobby area, and it would not be readily accessible to residents because they would have to ask a staff member to open the door for them. LVN B stated he has not received any requests from residents and/or visitors to review the survey binder. During an observation and interview on 03/13/24 at 9:11 am, LVN E looked for the survey results in the nurses' station and stated she could not find it. LVN E said the only survey results binder was in the lobby area. During an observation and interview on 03/13/24 at 9:13 am, the DON stated the survey binder was in the lobby area. The DON did not answer if survey results were readily accessible to residents instead, she kept answering i guess we can move it (survey binder). During an interview on 3/14/24 at 11:08 am, the Administrator stated the survey results binder was recently moved, and was not aware that it was not readily accessible. The Administrator stated he had not recently received complaints regarding the survey results not being readily accessible. Record review of Displaying of Required Notices and Signage (not dated) read in part the facility will display required state and federal notices and signage that affect or concern employees, residents and/or visitors. The policy did not address the survey results. 43871

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on interview and record review the facility failed to immediately notify and consult with the resident ' s physician when there was a significant change in a resident ' s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 21 (Resident #283) residents reviewed for change in condition. The facility failed to immediately inform NP/MD of Resident #283 change in condition addressing her behaviors towards wearing her Prevalon boots as orderd by the physician for healing of pressure ulcers. This failure placed Resident #283 at risk of serious decrease in health related to delayed treatment of healing her pressure ulcers. Findings included: Record Review of Resident #283 face sheet dated 03/14/2024 revealed she was an [AGE] year old and was initially admitted to the facility on [DATE]. Record Review of Resident #283 quarterly MDS dated [DATE] revealed she has been accounted for unstageable pressure ulcers. Record Review of Resident #283 ' s care plan dated 03/01/2024, Resident #283 presents with an unstageable pressure wound of the right heel 2x2cm interventions; evaluated skin, Skin during showers, provide pressure reducing surfaces on bed and chair, Repositioning Schedule, Perform wound care as ordered, maintain pain meds Record Review of Resident #283 ' s Care Plan dated 03/01/24, Resident #283 presents with an unstageable pressure wound of the left heel 1.5x1.5cm. Interventions state; Provide pressure reducing surfaces on bed and chair, Repositioning Schedule, Perform wound care as ordered, maintain pain meds Record Review of Resident #283 ' s care plan interventions dated 03/04/2024, revealed that interventions are in place to minimize risk for skin breakdown daily and ongoing over the next 90 days. One Interventions included provide treatment as ordered by physician. Record Review of Resident #283 physician orders start date 03/01/2024 revealed, Patient to wear Prevalon boots to bilateral feel while in bed. During an observation on 03/11/24 at 09:45 am, Resident #283 was lying asleep in bed and Prevalon boots were seen on top of laundry hamper and not on Resident #283 feet. During an observation on 03/13/2024 at 02:42 pm, Resident #283 was asleep in bed and Prevalon boots were on Residents #283 wheelchair and not on her feet. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview and observation on 03/13/2024 at 04:49 pm, with LVN B, stated that Resident #283 ulcers are unstageable and are DTI wound. State RN Surveyor N was present during observation of pressure ulcer wounds. LVN B indicated that Resident #283 has behaviors and does not want the Prevalon boots on, her behaviors are ongoing where she moves her feet back and forth removing the Prevalon boots, or she would put her feet to the side of the bed where she tries to remove them by kicking them off. The resident is then redirected. LVN B indicated that her behaviors are reported on the 24-hour report or on the progress notes, but her behaviors are not care planned. LVN B then placed Prevalon boots on Resident#283 feet. The Prevalon boots were on the wheelchair of the Resident. During an observation on 03/14/204 at 09:30 a.m., Resident #283 was in bed asleep with no Prevalon boots on. In an interview on 03/14/2024 at 11:30 am, with CNA G stated that if Resident #283 does take Prevalon boots off they are to notify the nurse or LVN who will then add it into the 24-hour report notes. In an interview on 03/14/24 at 02:35 pm, ADON D stated that if Resident #283 was having ongoing behaviors of her removing the prevelon boots they should have reported it on the 24-hour reports, or on the progress notes. Which would have indicated a triggered alert for a behavioral plan to be implemented on the MDS but there was not anything reported. ADON D looked through progress notes and care plan, but the only thing documented was on 03/13/2024. ADON D stated that the risk of her Resident not wearing the Prevalon boots as ordered could result in the wounds getting worse and not healing. In an interview on 03/14/2024, at 03:21pm with LVN B stated that prior to yesterday he did not report that she was having behaviors regarding removing her Prevalon boots, and that no one has reported to him that she takes them off. LVN B stated that it's here and there when she has behaviors and not really ongoing. LVN B stated it is the responsibility of any CNA or any staff to place the boots on and report it if she is having behaviors, but it is mainly the CNA ' s because they are the ones who place her in bed and back to the wheelchair. Record review of the facility policy Change in a Residents condition Status dated April 2007 states the facility shall promptly notify the resident, his or her attending physicians, and representative (sponsor) of changes in the resident ' s medical mental condition and/or status. The Nurse supervisor/charge nurse will notify the residents attending physician or on call physician when there has been a change; F. Refusal of treatment of medications (two or more consecutive times), I. Instructions to notify the physicians of changes in the resident ' s condition.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43871

Based on interview and record review, the facility failed to ensure the prompt resolution of all grievances to include ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed, any corrective action or to be taken by the facility as a result of the grievance, and the date when the decision was issued for 2 of 6 (Resident #383 and Resident #61) reviewed for resident rights.

The facility failed to initiate and complete a grievance for Resident #383's family who complained of Resident #61.

The facility failed to initiate and complete a grievance for Resident #61 who did not want to move rooms and room change notice was not provided.

These failures could place residents at risk for grievances not being addressed or resolved promptly.

Findings included:

Resident #383

Record review of Resident #383'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 #383's history and physical dated 2/7/24 revealed diagnoses of dementia with agitation.

Record review of Resident #383's progress notes from 1/25/24 through 2/9/24 revealed no documentation regarding her family concerns regarding Resident #61's verbal aggression that was reported to SW.

A call was placed to Resident #383's RP on 3/14/24 at 9:40 am, the 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.

Reviewed grievances for January 2024, February 2024, and March 2024 no grievance was found for Resident #383s' complaint regarding Resident #61 verbal aggression.

Resident #61

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].

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F 0585 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 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 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. [Resident #61's family member] then appeared in hallway and SW and administrator spoke with niece to inform her of events that transpired. 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. [Resident #61] then spoke to the Administrator and notified him that she was scared of him and that he as forcefully moved her to room. Ombudsman also verbalized requiring a written notice and advance notice of room change. Administrator reported that change was done to avoid further escalation of confrontation. [Resident #61] remained in 100 hall. Family to be notified of any and all changes with resident and all aspects of care. (continued on next page)

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F 0585 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 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. 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 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. She continues to state 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 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. 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. [Resident #61]'s family member was in the meeting and her niece was in the meeting with the Social worker as well. 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. Reviewed grievances for January 2024, February 2024, and March 2024 no grievance was found for Resident #61s complaint of not wanting to move rooms and written notice not provided. 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 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. (continued on next page)

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F 0585 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. 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 they had discussed the room change in which Resident #61 had voiced the Administrator had forced her out of the room by pushing her with the wheelchair. The SW stated she did not complete a grievance for either Resident #383's family complaint regarding Resident #61 and did not complete grievance for Resident #61's refusal of being moved and/or families concerns regarding how the situation was handled. The SW stated because the issue was resolved then, she did not complete a grievance form. The SW stated per policy a grievance should had been completed to have proper documentation on actions taken and follow up with both parties. During an interview on 3/14/24 at 11:08 am, the Administrator stated he did not know if grievance should had been completed for Resident #383's complaint regarding Resident #61. The Administrator reviewed policy and stated based on policy it was expected for the SW to complete a grievance for Resident #383. The Administrator stated there was no risk because it was resolved the same day and both parties were good with outcome. Record review of Filing Grievances/ Complaints policy dated March 2023 read in part our facility will assist resident's individual representative (sponsors), other interested family members, or residents' advocates in filing grievances or complaints when such requests are made. Grievances and/or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint on behalf of the resident. Upon receipt of a written grievance and/or complaint, the Grievance Official will investigate the allegations and submit a written report of such findings.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 6 (Resident #61) residents reviewed for abuse. The facility failed to implement their abuse policy on reporting to State Office Resident #61's allegation of the Administrator slapping hand when forced out of her room. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings include: 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. 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 . (continued on next page)

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F 0609 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 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. 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. (continued on next page)

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F 0609 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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 6 (Resident #61) residents reviewed for abuse. The facility failed to ensure Resident #61's allegation of the Administrator slapping hand when forced out of her room was thoroughly investigated. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings include: 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. 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 . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that assessments accurately reflected residents ' status for 1 (Resident # 30) of 21 residents reviewed for accuracy of assessment. The facility failed to ensure that Resident #30 ' s MDS reflected her refusal to use her C-PAP machine (machine that uses air pressure to help breathing). This failure put residents at risk of poor sleep, increased incidence of sleep apnea (sleep disorder where breathing stops and starts). Findings included: Record review of Resident #30 ' s face sheet dated 03/14/2023 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #30 ' s History and Physical dated 02/21/2023 reveled she had diagnoses including COPD (Chronic Obstructive Pulmonary disease - a condition where airways are narrowed, and breathing is difficult); Chronic respiratory failure with hypoxia (a condition where airways are narrowed or damaged and there is reduced oxygen in the blood); Sleep disorder (changes in sleep that can negatively affect health.) Medications included a CPAP to be used nightly and 2 liters per minute of oxygen at night as needed. The History and Physical revealed that Resident #30 ' s family member said that facility staff was not placing her CPAP because the distilled water in the machine had not been used. The resident said she was not sleeping, although staff reported she was. Record review of Resident #30 ' s quarterly MDS dated [DATE] revealed she had a BIMS of 9 (Moderate cognitive impairment). She had no symptoms of delirium or psychosis. She had no behavioral symptoms including rejection of care during the 7-day look back period. She had diagnoses including COPD or chronic lung disease, and Respiratory failure. The MDS indicated she was not receiving oxygen therapy. Record review of Resident #30 ' s Care plan dated 01/26/2023 revealed she refused to use her C-Pap Machine. Record review of Resident #30 ' s physicians orders dated 11/15/2023 revealed she was to use a CPAP machine daily at bedtime. The physician's order dated 01/26/2024 revealed that her compliance with use of the CPAP machine was to be documented in progress notes and the physician was to be notified if she was noncompliant. Record review of Resident #30 ' s progress note by LVN A dated 1/9/2024 revealed the resident was prompted throughout the night to keep her c-pap on with no success. The resident had intermittent labored breathing. Record review of Resident #30 ' s MAR for February 2024 revealed she was non-complaint with use of the CPAP machine on 02/14/2024 and 02/23/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30 ' s nursing progress notes February 2024 revealed no corresponding nursing notes regarding her refusal to use the CPAP machine as required by physician ' s order. Record review of Resident #30 ' s MAR for March 2024 (03/01/2024 - 03/12/2024) revealed she had no instances of non-compliance with use of the CPAP machine. Record review of Resident #30 ' s respiratory therapy report dated 03/14/2024 for 12/15/2023 - 03/13/2024 revealed she used the CPAP machine 33 out of 90 days and had not used the CPAP machine on 57 nights. During February 2024 she did not use the CPAP machine on 02/01, 02/02, 02/03, 02/04, 02/07, 02/09, 02/10, 02/14, 02/16, 02/17, 02/19, 02/22, 02/23, 02/24, 02/28 and 02/29/2024. Between 03/01/2024 and 03/13/2024 she did not use the CPAP machine the nights of 03/01, 03/02, 03/01, 03/08, 03/09, 03/11, 03/12 and 03/13/2024. In an interview on 03/11/24 at 11:19 AM Resident #30 ' s family member said that staff were not putting the CPAP on the resident at night. The family member said a man came in to look at the machine and said they [nursing staff] do not put it on her. The resident said she had difficulty putting the CPAP mask by herself. In a telephone interview on 03/14/24 at 09:28 AM Respiratory Therapist C revealed that he was familiar with Resident #30 and that he could provide records of her use of the CPAP machine. In an interview on 03/14/24 at 11:34 AM Respiratory Therapist C revealed that review of Resident #30 Therapy Report documented that in March 2024 the resident did not have the CPAP mask on at all, and that between 12/15 and 3/13 she did not use the CPAP machine 57 times. The Respiratory Therapist stated that not using the CPAP machine put Resident #30 at risk of poor sleep quality and increased instances of sleep apnea. In an interview on 03/14/24 at 02:10 PM the DON revealed that nurse should be documenting if Resident #30 refused to use her CPAP machine. She stated that without the use of the CPAP machine the resident would be at increased risk of sleep apnea and might lose breathing at night. She said the nurses should be following physician ' s orders to document instances when Resident #30 refused to use the CPAP machine. In an interview on 03/14/24 at 02:28 PM ADON D revealed she thought Resident #30 was generally compliant with all orders including use of the CPAP machine. She stated that noncompliance with use of the CPAP machine could result in Resident #30 ' s feeling winded, short of breath, and might exacerbate her COPD. In an interview on 03/14/24 at 04:16 PM LVN A revealed that during the time she had worked with Resident 30, she had been told by other staff that the resident refused to use the CPAP machine. LVN A said she put the CPAP mask on Resident #30 because the resident was not able to put it on herself. The LVN said she had not had any difficulties with Resident #30 ' s use of the CPAP after educating the resident about the risks of not using the CPAP. The LVN said that if the resident did not want to put the machine on right away the LVN would go back and put it on her later in the evening. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy Resident Assessment Instrument (MDS 2.0) revised 04/2007 revealed in part that the purpose of the resident assessment was to describe resident ' s capability to perform daily life functions and to identify significant impairments in functional capacity. The information derived from the assessment enabled the staff to plan care to allow the resident to reach his/her highest practicable level of function to include behavioral symptoms.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49850 Based on observation, interview and record review the facility failed to ensure that resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #283) of five residents reviewed for treatment to address pressure ulcers. The facility failed to ensure that Resident #283 wore Prevalon boots while in bed as per physician ' s orders. This failure placed Resident #283 at risk of serious decrease in health related to delayed treatment of healing her pressure ulcers. Findings included: Record Review of Resident #283 face sheet dated 03/14/2024 revealed she was an [AGE] year-old and was initially admitted to the facility on [DATE]. Record Review of Resident #283 quarterly MDS dated [DATE] revealed she has been accounted for unstageable pressure ulcers. Record Review of Resident #283 ' s care plan dated 03/01/2024, revealed Resident #283 presents with an unstageable pressure wound of the right heel 2x2cm and ,. Further review of the care plan revealed an unstageable pressure wound of the left heel 1.5x1.5cm. Interventions state; evaluate skin, provide pressure reducing surfaces on bed and chair, Repositioning Schedule, Perform wound care as ordered, maintain pain meds. Other interventions dated 03/04/2024, revealed minimize risk for skin breakdown daily and ongoing over the next 90 days. One Interventions includes provide treatment as ordered by physician. Record Review of Resident #283 physician orders start date 03/01/2024 revealed, Patient to wear Prevalon boots to bilateral feel while in bed. During an observation on 03/11/24 at 09:45 am, Resident #283 was lying asleep in bed and Prevalon boots were seen on top of laundry hamper and not on Resident #283 feet. During an observation on 03/13/2024 at 02:42 pm, Resident #283 was asleep in bed and Prevalon boots were on Residents #283 wheelchair and not on her feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 03/13/2024 at 04:49 pm with LVN B revealed that Resident #283 DTI (maroon localized area of discolored intact skin due to damage of underlying soft tissue from pressure and/or shear) to bilateral heels. LVN B indicated that Resident #283 had behaviors and does not want the Prevalon boots on, her behaviors are ongoing where she moves her feet back and forth removing the Prevalon boots, or she would put her feet to the side of the bed where she tries to remove them by kicking them off. The resident is then redirected. LVN B indicated that her behaviors are reported on the 24-hour report or on the progress notes, but her behaviors are not care planned. LVN B then placed Prevalon boots on Resident#283 feet. The Prevalon boots were on the wheelchair of the Resident. During an observation on 03/14/204 at 09:30 a.m., Resident #283 was in bed asleep with no Prevalon boots on. In an interview on 03/14/2024 at 11:30 am, with CNA G stated that if Resident #283 does take Prevalon boots off they are to notify the nurse or LVN who will then add it into the 24-hour report notes. In an interview on 03/14/24 at 02:35 pm, with ADON D stated that if Resident #283 was having ongoing behaviors of her removing the Prevalon boots they should have reported it on the 24 hour reports, or on the progress notes. Which would have indicated a triggered alert for a behavioral plan to be implemented on the MDS but there was not anything reported. ADON D looked through progress notes and care plan but the only thing documented was on 03/13/2024. ADON D stated that the risk of her Resident not wearing the Prevalon boots as ordered could result in the wounds getting worse and not healing. In an interview on 03/14/2024, at 03:21pm with LVN B stated that prior to yesterday he did not report that she was having behaviors regarding removing her Prevalon boots, and that no one has reported to him that she takes them off. LVN B stated that it's here and there when she has behaviors and not really ongoing. LVN B stated it is the responsibility of any CNA or any staff to place the boots on and report it if she is having behaviors, but it is mainly the CNA ' s because they are the ones who place her in bed and back to the wheelchair. Policy for pressure ulcer was not obtained.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as is possible for1 (Resident #37) of 21 residents reviewed for an environment free of accident hazards as possible. The facility failed to ensure that the mechanical lift (Hoyer) sling used to transfer Resident #37 was in good working order, resulting in a sling strap tearing, and Resident #37 falling to the floor. This failure could result in residents fearing transfers using a mechanical lift, and serious injury, including fractures. Findings included: Record review of Resident #37 ' s face sheet dated 03/14/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #37 ' s quarterly MDS dated [DATE] revealed he had a BIMS score of 12 (moderate cognitive impairment). He was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and personal hygiene. He was dependent on staff for bed to chair/ chair to bed transfers and tub/shower transfers. He was always incontinent of bowel and bladder. His diagnoses included end-stage renal disease (kidney failure), heart failure, morbid obesity, Record review of Resident #37 ' s care plan dated 03/07/2024 revealed he was at risk for falls, and the Maintenance department was to check all Hoyer lift nets and straps to make sure they were not torn or old and could be used safely. His care plan dated 06/20/2023 revealed he would receive assistance with ADLs. Record review of Resident #37 ' s Resident Incident Report dated 03/14/2024 revealed that on 03/06/2024 he was being transferred from a shower chair in a Hoyer sling when the Hoyer strap broke. He was observed to be on the floor on his left side and said he had pain on his left leg. His physician was notified and x-ways of his left hip and leg were ordered. Record review of Resident #37 ' s Nursing Progress Note dated 03/06/2024 revealed that at 2:45 PM a CNA (unidentified) called LVN I into his room and where the resident was observed laying on the floor on his left side. Per the CNAs (2) they were transferring the resident onto the bed after his shower when the Hoyer strap broke. The resident voiced pain to the left leg down to the ankle. The resident was able to move his left arm and denied any new pain except throbbing to his left leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview and observation on 03/11/24 at 10:58 AM Resident #37 revealed that on the past Wednesday [03/06/2024] staff members were transferring him in a Hoyer lift when the sling broke and he fell to the ground landing on his left side. Resident #37 was observed to have a bruise on his left wrist. Resident #37 said an x-ray machine was brought om and they did [his] whole left side and found nothing. He said that he hit his left foot on the lift and that his side under his left breast hurt. In an interview on 03/14/24 at 11:53 AM CNA J confirmed she had received prior training to check Hoyer slings to make sure they were in good condition In an interview on 03/14/24 11:28 AM CNA K confirmed she had received prior training to check Hoyer slings to make sure they were in good condition In an interview on 03/14/24 a 12:09 PM the Lead CNA confirmed she had received prior training to check Hoyer slings to make sure they were in good condition In an interview on 03/14/24 at 01:28 PM LaundryWorker M revealed she had been instructed and does inspect Hoyer nets for wear. She said that if there was a problem with the condition of the sling, she would tell the Maintenance/Housekeeping Manager. In an interview on 03/14/2024 at 2:55 PM the DON said that as a result of Resident #37 ' s fall staff had been in serviced to make sure to hook the Hoyer sling to the mechanical lift using two loops instead of one. Record review of the facility policy Safe Lifting and Movement of Residents revised 4/2007 revealed that the facility would use mechanical lifting devices to protect the safety and well-being of residents. Mechanical lift equipment shall undergo routine checks and maintenance by nursing and maintenance staff to ensure that equipment remains in good working order.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review the facility failed to ensure resident with urinary incontinence, based on the resident ' s comprehensive assessment, the facility must ensure that the resident receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 (Resident #32) residents reviewed for urinary catheter. The facility failed to ensure Resident #32 ' s subpubic catheter was properly secured. This failure placed residents at risk of possible pain and trauma due to the catheter not being properly secured on the leg. Findings included: Record review of Resident #32 ' s history and physical dated 11/23/2023 revealed diagnoses of UTI (urinary tract infection), dementia, suprapubic catheter. Record review of Resident #32 ' s quarterly MDS assessment dated [DATE] revealed he had a BIMS of 3 (cognitively severely impaired) and had a dwelling catheter. Record review of Resident #32 ' s care plan dated 12/05/2023 revealed Resident #32 has a subpubic catheter: Indwelling related to obstructive uropathy with interventions of Secure tubing to thigh to prevent pulling. Record review of Resident #32 ' s physician order dated 8/25/23 revealed Leg strap placement check every shift. During an observation and interview on 3/13/24 at 9:41 am, CNA F stated the resident ' s catheter was not properly secured. The patch was dated 2/14/24. CNA F stated the nurse knew about it since the nurse is the one that replaces the patch. The lock on the patch was not latching to keep the catheter secure and stated it had been like that for a while but did not specify how long. CNA F stated that the risk included pulling on the catheter when staff is provided care. Interview on 03/13/24 9:52 AM, LVN E said the catheter was below the bladder. The catheter was not properly secured. The latch was not latching or locking correctly. LVN E stated that the nurses and CNAs were responsible for checking that catheters are positioned correctly. LVN C said the risk of pulling a catheter could cause trauma. LVN E said that on the 6th and 20th of every month, catheters for residents need to be changed. LVN E stated that the patch was dated 2/21/24. LVN E said the patch was changed as needed. LVN E said she does not receive reports if a CNA or an LVN finds the catheter was not secured properly. LVN E said that staff receive training online regarding catheters twice a year. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 03/13/24 02:00 PM LVN E, stated that catheters need to be checked every time that the resident was changed. LVN E said that Resident #32 changed every 2 hours because he needs to be repositioned. LVN E said that Resident #32 E can communicate if he's in pain and he will notify the staff. In an interview on 03/14/24 01:30 PM with DON, she stated that for urinary catheters to be properly secured, they need to be secured with the immobilizer device, which goes on their leg or thigh, that way it is secure and not bothering the patient. The DON said the staff responsible for checking for the catheter was the nurse in charge of the resident, but it was expected that the CNA's also check and make sure it's stabilized. The DON said that if a CNA observes that if a catheter was not stabilized or properly secure, the CNA would need to communicate it to the nurse after putting the catheter to the side and has made sure that it's not bothering the resident and that the catheter bag is not touching the floor. The DON stated that staff checks that the catheters are secured as needed and throughout the shift. She said that the person responsible for overseeing the Nurses and CNAs are checking the catheters is the ADON and then the DON supervises her. DON said that the risk of a catheter not being properly secured is that the catheter can hurt the resident. The resident can start bleeding and it can worsen the situation. DON stated that if a Nurse or CNA finds a catheter not properly secure, the expectation is for the nurse to remove the patch and put a new one that can properly secure the catheter. DON stated that the last in-service regarding catheters was provided on February 22, 2024. She stated that she does not know how often it needs to be done.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34486

Based on interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with the comprehensive person-centered care plan, the residents' goals and preferences for one (Resident #30) of four residents reviewed for provision of respiratory care.

Resident #30 was not assisted in putting on her CPAP mask every night as per physician ' s orders.

This failure could result in residents having increased difficulty sleeping, decreased sleep quality, and increased instances of sleep apnea (a sleep disorder where breathing stops and starts).

Findings included:

Record review of Resident #30 ' s face sheet dated 03/14/2023 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE].

Record review of Resident #30 ' s History and Physical dated 02/21/2023 reveled she had diagnoses including COPD (Chronic Obstructive Pulmonary disease - a condition where airways are narrowed, and breathing is difficult); Chronic respiratory failure with hypoxia (a condition where airways are narrowed or damaged and there is reduced oxygen in the blood); Sleep disorder (changes in sleep that can negatively affect health.) Medications included a CPAP to be used nightly and 2 liters per minute of oxygen at night as needed. The History and Physical revealed that Resident #30 ' s family member said that facility staff was not placing her CPAP because the distilled water in the machine had not been used. The resident said she was not sleeping, although staff reported she was.

Record review of Resident #30 ' s quarterly MDS dated [DATE] revealed she had a BIMS of 9 (Moderate cognitive impairment). She had no symptoms of delirium or psychosis. She had no behavioral symptoms including rejection of care during the 7-day look back period. She had diagnoses including COPD or chronic lung disease, and Respiratory failure. The MDS indicated she was not receiving oxygen therapy.

Record review of Resident #30 ' s Care plan dated 01/26/2023 revealed she refused to use her C-Pap Machine. The goal was that her episodes of refusing to use the CPAP machine would diminish. Interventions included to report CPAP refusal to the physician, and explain why the CPAP was important. The Care Plan did not address the difficulty the resident had trying to put the CPAP machine on herself.

Record review of Resident #30 ' s physicians orders dated 11/15/2023 revealed she was to use a CPAP machine daily at bedtime. The physician's order dated 01/26/2024 revealed that her compliance with use of the CPAP machine was to be documented in progress notes and the physician was to be notified if she was noncompliant.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30 ' s progress note by LVN A dated 1/9/2024 revealed the resident was prompted throughout the night to keep her c-pap on with no success. The resident had intermittent labored breathing. Record review of Resident #30 ' s MAR for February 2024 revealed she was non-complaint with use of the CPAP machine on 02/14/2024 and 02/23/2024. Record review of Resident #30 ' s nursing progress notes February 2024 revealed no corresponding nursing notes regarding her refusal to use the CPAP machine as required by physician ' s order. Record review of Resident #30 ' s MAR for March 2024 (03/01/2024 - 03/12/2024) revealed she had no instances of non-compliance with use of the CPAP machine. Record review of Resident #30 ' s respiratory therapy report dated 03/14/2024 for 12/15/2023 - 03/13/2024 revealed she used the CPAP machine 33 out of 90 days and had not used the CPAP machine on 57 nights. During February 2024 she did not use the CPAP machine on 02/01, 02/02, 02/03, 02/04, 02/07, 02/09, 02/10, 02/14, 02/16, 02/17, 02/19, 02/22, 02/23, 02/24, 02/28 and 02/29/2024. Between 03/01/2024 and 03/13/2024 she did not use the CPAP machine the nights of 03/01, 03/02, 03/01, 03/08, 03/09, 03/11, 03/12 and 03/13/2024. In an interview on 03/11/24 at 11:19 AM Resident #30 ' s family member said that staff were not putting the CPAP on the resident at night. The family member said a man came in to look at the machine and said they [nursing staff] do not put it on her. The resident said she had difficulty putting the CPAP mask by herself. In a telephone interview on 03/14/24 at 09:28 AM Respiratory Therapist C revealed that he was familiar with Resident #30 and that he could provide records of her use of the CPAP machine. In an interview on 03/14/24 at 11:34 AM Respiratory Therapist C revealed that review of Resident #30 Therapy Report documented that in March 2024 the resident did not have the CPAP mask on at all, and that between 12/15 and 3/13 she did not use the CPAP machine 57 times. The Respiratory Therapist state that not using the CPAP machine put Resident #30 at risk of poor sleep quality and increased instances of sleep apnea. In an interview on 03/14/24 at 02:10 PM the DON revealed that nurse should be documenting if Resident #30 refused to use her CPAP machine. She stated that without the use of the CPAP machine the resident would be at increased risk of sleep apnea and might lose breathing at night. She said the nurses should be following physician ' s orders to document instances when Resident #30 refused to use the CPAP machine. In an interview on 03/14/24 at 02:28 PM ADON D revealed she thought Resident #30 was generally compliant with all orders including use of the CPAP machine. She stated that noncompliance with use of the CPAP machine could result in Resident #30 ' s feeling winded, short of breath, and might exacerbate her COPD. (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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/14/24 at 04:16 PM LVN A revealed that during the time she had worked with Resident 30, she had been told by other staff that the resident refused to use the CPAP machine. LVN A said she put the CPAP mask on Resident #30 herself because the resident was not able to put it on herself. The LVN said she had not had any difficulties with Resident #30 ' s use of the CPAP after educating the resident about the risks of not using the CPAP. The LVN said that if the resident did not want to put the machine on right away the LVN would go back and put it on her later in the evening.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43871 Based on observations, interviews, and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors for 1 of 4 days reviewed and the census was wrongly documented. The facility failed to post the required staffing information for 3/11/24. The facility failed to accurately document the census for 60 days of 73 days reviewed in January 2024, February 2024, and March 1st through the 13th. This failure could place residents, their families, and facilities, and visitors at risk of not having access to correct information regarding staffing data and facility census. Findings included: During an observation on 3/11/24 at 9:17 am, the public access area nursing station had a daily sheet posting information which included facility name, census, total hours for RNs,. LVNs, CNAs, MAs, and shift times that was dated 3/10/24. During an observation on 3/11/24 at 12:01 pm, the public access area nursing station had a daily sheet posting information which included facility name, census, total hours for RNs,. LVNs, CNAs, MAs, and shift times that was dated 3/10/24. Record review of January 2024 census revealed, 1/1/24 the census was 85. The direct care staffing log dated 1/1/24 revealed census of 83. Record review of January 2024 census revealed, 1/2/24 the census was 84. The direct care staffing log dated 1/2/24 revealed census of 83. Record review of January 2024 census revealed, 1/3/24 the census was 85. The direct care staffing log dated 1/3/24 revealed census of 83. Record review of January 2024 census revealed, 1/4/24 the census was 86. The direct care staffing log dated 1/4/24 revealed census of 84. Record review of January 2024 census revealed, 1/5/24 the census was 85. The direct care staffing log dated 1/5/24 revealed census of 86. Record review of January 2024 census revealed, 1/6/24 the census was 85. The direct care staffing log dated 1/6/24 revealed census of 86. Record review of January 2024 census revealed, 1/7/24 the census was 84. The direct care staffing log dated 1/7/24 revealed census of 86. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of January 2024 census revealed, 1/8/24 the census was 84. The direct care staffing log dated 1/8/24 revealed census of 86. Record review of January 2024 census revealed, 1/9/24 the census was 85. The direct care staffing log dated 1/9/24 revealed census of 86. Record review of January 2024 census revealed, 1/10/24 the census was 84. The direct care staffing log dated 1/10/24 revealed census of 83. Record review of January 2024 census revealed, 1/11/24 the census was 85. The direct care staffing log dated 1/11/24 revealed census of 83. Record review of January 2024 census revealed, 1/13/24 the census was 81. The direct care staffing log dated 1/13/24 revealed census of 84. Record review of January 2024 census revealed, 1/14/24 the census was 81. The direct care staffing log dated 1/14/24 revealed census of 84. Record review of January 2024 census revealed, 1/15/24 the census was 82. The direct care staffing log dated 1/15/24 revealed census of 84. Record review of January 2024 census revealed, 1/16/24 the census was 82. The direct care staffing log dated 1/16/24 revealed census of 81. Record review of January 2024 census revealed, 1/17/24 the census was 83. The direct care staffing log dated 1/17/24 revealed census of 82. Record review of January 2024 census revealed, 1/19/24 the census was 80. The direct care staffing log dated 1/19/24 revealed census of 82. Record review of January 2024 census revealed, 1/20/24 the census was 80. The direct care staffing log dated 1/20/24 revealed census of 82. Record review of January 2024 census revealed, 1/20/24 the census was 80. The direct care staffing log dated 1/20/24 revealed census of 82. Record review of January 2024 census revealed, 1/21/24 the census was 79. The direct care staffing log dated 1/21/24 revealed the census was blank. Record review of January 2024 census revealed, 1/22/24 the census was 80. The direct care staffing log dated 1/22/24 revealed census of 82. Record review of January 2024 census revealed, 1/23/24 the census was 79. The direct care staffing log dated 1/23/24 revealed the census was blank. Record review of January 2024 census revealed, 1/24/24 the census was 81. The direct care staffing log dated 1/24/24 revealed census of 80. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of January 2024 census revealed, 1/25/24 the census was 79. The direct care staffing log dated 1/25/24 revealed census of 81. Record review of January 2024 census revealed, 1/26/24 the census was 80. The direct care staffing log dated 1/26/24 revealed census of 81. Record review of January 2024 census revealed, 1/28/24 the census was 80. The direct care staffing log dated 1/28/24 revealed census of 79. Record review of January 2024 census revealed, 1/29/24 the census was 80. The direct care staffing log dated 1/29/24 revealed census of 79. Record review of January 2024 census revealed, 1/30/24 the census was 82. The direct care staffing log dated 1/30/24 revealed census of 80. Record review of January 2024 census revealed, 1/31/24 the census was 80. The direct care staffing log dated 1/31/24 revealed census of 81. Record review of February 2024 census revealed, 2/1/24 the census was 79. The direct care staffing log dated 2/1/24 revealed census of 80. Record review of February 2024 census revealed, 2/2/24 the census was 79. The direct care staffing log dated 2/2/24 revealed census of 80. Record review of February 2024 census revealed, 2/4/24 the census was 78. The direct care staffing log dated 2/4/24 revealed census of 79. Record review of February 2024 census revealed, 2/5/24 the census was 78. The direct care staffing log dated 2/5/24 revealed census of 79. Record review of February 2024 census revealed, 2/6/24 the census was 78. The direct care staffing log dated 2/6/24 revealed census of 81. Record review of February 2024 census revealed, 2/7/24 the census was 79. The direct care staffing log dated 2/7/24 revealed census of 77. Record review of February 2024 census revealed, 2/8/24 the census was 79. The direct care staffing log dated 2/8/24 revealed census of 77. Record review of February 2024 census revealed, 2/9/24 the census was 78. The direct care staffing log dated 2/9/24 revealed census of 77. Record review of February 2024 census revealed, 2/10/24 the census was 78. The direct care staffing log dated 2/10/24 revealed census of 79. Record review of February 2024 census revealed, 2/11/24 the census was 76. The direct care staffing log dated 2/11/24 revealed census of 79. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of February 2024 census revealed, 2/12/24 the census was 76. The direct care staffing log dated 2/12/24 revealed census of 79. Record review of February 2024 census revealed, 2/13/24 the census was 73. The direct care staffing log dated 2/13/24 revealed census of 75. Record review of February 2024 census revealed, 2/14/24 the census was 74. The direct care staffing log dated 2/14/24 revealed census of 75. Record review of February 2024 census revealed, 2/15/24 the census was 74. The direct care staffing log dated 2/15/24 revealed census of 73. Record review of February 2024 census revealed, 2/16/24 the census was 74. The direct care staffing log dated 2/16/24 revealed census of 73. Record review of February 2024 census revealed, 2/19/24 the census was 75. The direct care staffing log dated 2/19/24 revealed census of 74. Record review of February 2024 census revealed, 2/20/24 the census was 75. The direct care staffing log dated 2/20/24 revealed census of 74. Record review of February 2024 census revealed, 2/21/24 the census was 77. The direct care staffing log dated 2/21/24 revealed census of 75. Record review of February 2024 census revealed, 2/22/24 the census was 77. The direct care staffing log dated 2/22/24 revealed census of 75. Record review of February 2024 census revealed, 2/24/24 the census was 78. The direct care staffing log dated 2/24/24 revealed census of 79. Record review of February 2024 census revealed, 2/25/24 the census was 79. The direct care staffing log dated 2/25/24 revealed census of 80. Record review of February 2024 census revealed, 2/26/24 the census was 80. The direct care staffing log dated 2/26/24 revealed census of 77. Record review of February 2024 census revealed, 2/27/24 the census was 81. The direct care staffing log dated 2/27/24 revealed census of 78. Record review of February 2024 census revealed, 2/28/24 the census was 81. The direct care staffing log dated 2/28/24 revealed census of 81. Record review of March 2024 census revealed, 3/2/24 the census was 81. The direct care staffing log dated 3/2/24 revealed census of 80. Record review of March 2024 census revealed, 3/3/24 the census was 81. The direct care staffing log dated 3/3/24 revealed census of 80. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of March 2024 census revealed, 3/5/24 the census was 79. The direct care staffing log dated 3/5/24 revealed census of 81. Record review of March 2024 census revealed, 3/6/24 the census was 77. The direct care staffing log dated 3/6/24 revealed census of 81. Record review of March 2024 census revealed, 3/7/24 the census was 77. The direct care staffing log dated 3/7/24 revealed census of 78. Record review of March 2024 census revealed, 3/9/24 the census was 75. The direct care staffing log dated 3/9/24 revealed census of 77. Record review of March 2024 census revealed, 3/10/24 the census was 75. The direct care staffing log dated 3/10/24 revealed census of 77. Record review of March 2024 census revealed, 3/11/24 the census was 75. The direct care staffing log dated 3/11/24 revealed the census was blank. Record review of March 2024 census revealed, 3/12/24 the census was 77. The direct care staffing log dated 3/12/24 revealed census of 75. During an interview on 3/14/24 at 11:39 am, the ADON stated the Lead CNA was responsible for completing the daily staffing posting. The ADON stated the Lead CNA had a binder with the copies in place where she prefilled the dates for a weeks' worth and would complete the daily staffing census the day before and would leave it for the nurses to post the following morning. The ADON stated the nurses and/or the Lead CNA would have to verify the daily census at the beginning of the shift. The ADON stated she did not know what kind of risk there was for the census not being accurate and stated she knew it was a State Office requirement. During an interview on 3/14/24 at 12:03 pm, the Lead CNA stated she was responsible for completing the daily staffing sheet. The Lead CNA stated she would complete the daily staffing sheet at the end of the shift for the following day and would leave it in the nurse's station for the nurses to post in the morning. The Lead CNA did not have an answer for the census being wrong and did not know of any risk for the daily census being wrong . Record review of Posting Direct Care Daily Staffing Number policy dated July 2016 read in part our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Shift information shall be recorded on the nursing staff directly responsible for resident care form for each shift. The information recorded on the form shall include: the resident census at the beginning of the shift for which the information is posted. Within 2 hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the nursing staff directly responsible for resident care form/ the shift supervisor shall date the form, record the census, and post the staffing information in the location designated by

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observations, interviews, and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 3 of 6 medications carts (Hall 200, 300 and 400) reviewed for medication storage and 4 (#283, #51, #29, & #30) of 14 residents reviewed for medication administration. -The facility failed to have physician ' s orders that documented prescribed amount of water for G-Tube flush before and after medication administration for Resident #283. -The facility failed to administer prescribed medications according to physician ' s orders for Resident #30. -The facility failed to administer Nebulizer Medications according to pharmacy policies and procedures for Resident #29. - The facility failed to administer prescribed medications according to manufacture specifications for Residents #40 and #51. - The facility failed to ensure Licensed Staff LVN O and LVN Q did not sign off on the Controlled Drugs-Count Record form prior to counting and verifying that all controlled substances in the medication cart had been accounted for with the on-coming nurse at the change of shift. -The facility failed to ensure liquid medication stored in medication carts on three halls (200, 300 and 400) did not have dried drippings on the sides of the bottles. This failure could place residents at risk of harm or of not receiving desired outcomes from medications not administered according to physician orders. This failure could result in drug diversion of controlled substances. The findings included: Resident #283 Review of Face Sheet dated 03/14/24 at 12:20 PM for Resident #283 revealed admitted : 03/01/24 at 12:33 PM. Review of History & Physical dated 03/06/24 for Resident #283 revealed [AGE] year-old female with diagnoses of Gastrostomy (a tube inserted through the wall of the abdomen directly into the stomach used to give drugs and liquids, including liquid food, to the patient.) Dysphagia (swallowing difficulties), dementia, diastolic heart failure, type 2 diabetes mellitus (long term condition that happens because of a problem in the way the body regulates and uses sugar as fuel) , chronic kidney disease stage 3, and anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of MDS Entry Record revealed Resident #283 was admitted on [DATE] to Medicare and/or Medicaid Unit to room . Type of Entry: Admission. Review of Care Plan documented Start Date: 03/05/24 for Resident #283 revealed required feeding tube for nutrition due to Gastro. Record Review Physician's Orders dated March 2024 for Resident #283 did not document a Physician's Order to flush G-Tube (with 30 ml (about 1.01 oz) of water before and after medication administration and/or to flush G-Tube with 10 ml (about 0.34 oz) of water between medications. Review of Medication Administration Record dated March 2024 for Resident #283 documented Order Start Date: 03/13/24: Sucralfate 1 GM tablet three times daily before meals, crush and administer through GT at 10:00 AM, 2:00 PM, and 6:00 PM. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #283 provided by Medical Records revealed a new entry dated 03/14/24 and signed by LVN B documented Order Date: 03/13/24. Start Date: 03/13/24. Enteral Tube Flush: Flush with 30 cc water before med administration; Flush with 5 to 10 cc between each med administration; Flush with 30 cc water after med administration at 8:00 AM and 8:00 PM. An observation on 03/11/24 at 3:00 PM during Medication Administration with LVN B revealed Resident #283 had a G-Tube and he had held the enteral feeding x 30 minutes prior to administering medication. The nurse reported he was going to administer Sucralfate 1 GM one tablet via G-Tube. The nurse poured 10 ml (about 0.34 oz) of water in plastic cup and placed tablet to dissolve in water prior to entering resident's room. The nurse said he would flush the G-Tube with 30 ml (about 1.01 oz) of water before and after medication administration and 10 ml (about 0.34 oz) of water before and after medication administration. In an interview and record review on 03/13/24 at 1:45 PM with LVN B revealed Resident #283's Medication Administration Record did not have an entry to flush G-Tube with 30 ml (about 1.01 oz) of water before and after medication administration or to flush G-Tube with 10 ml (about 0.34 oz) of water between medications. LVN B stated, Resident #283 is a new admission and maybe that is why the Physician's Orders to flush G-Tube with 30 ml (about 1.01 oz) of water before and after medication administration or to flush G-Tube with 10 ml (about 0.34 oz) of water between medications are not on the Physician's Orders and Medication Administration Record. In an interview and record review on 03/13/24 at 1:57 PM, with the DON confirmed the Physician's Orders and Medication Administration Record dated March 2024 for Resident #283 did not document a doctor's orders to flush G-Tube with 30 ml (about 1.01 oz) of water before and after medication administration or to flush G-Tube with 10 ml (about 0.34 oz) of water between medications. The DON stated, the nurses need to get an order upon admission to flush G-Tube with 30 ml (about 1.01 oz) of water before and after medication administration or to flush G-Tube with 10 ml (about 0.34 oz) of water between medications (or prescribed amount). Resident # 30 Review of Face Sheet dated 03/14/24 9:40 AM, revealed admitted : 08/26/16; re-admitted [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of History & Physical dated 02/21/24 revealed 74 -year-old female with diagnoses of hypertension, ESRD (end stage renal disease) on hemodialysis three times a week, gastroparesis (disorder that slows or stops the movement of food from your stomach to the small intestine), diabetes mellitus type II, GERD (Gastroesophageal reflux disease is when the stomach contents move up into the esophagus). Review of Care Plan for Resident #30 revealed Start Date: Resident has potential for complications related to history of GERD such as belching, indigestion, esophageal/tooth erosion and/or bad chest discomfort. Interventions: Medication as ordered. Record Review 03/14/24 of Physician Orders dated March 2024 for Resident #30 revealed Sucralfate 1 GM give one tablet by mouth tid before meals. Diagnosis: Dependent on Renal Dialysis. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #30 revealed Sucralfate 1 GM give one tablet by mouth tid before meals at 8:00 AM, 12:00 PM, and 5:00 PM. Diagnosis: Dependent on Renal Dialysis. Review of facility Automated Dispensing Medication Cabinet Inventory Expiration Report dated 2024-03-12 at 16:32 CST provided by the DON did not list Sucralfate 1 GM. An observation and interview on 03/13/24 at 12:32 PM revealed during the Medication Administration with Medication Aide N she stated she needed to administer Sucralfate 1 GM one tablet by mouth before meals. Resident #30's family member asked the Medication Aide if she was going to give the resident her medications because the van driver was waiting to take her to dialysis. Medication Aide N informed the resident's familly member that she needed to administer one medication before she went to dialysis. Medication Aide N looked for medication in the second drawer of the medication cart and did not find the medication blister packet for Sucralfate 1 GM. Medication Aide checked the bottom drawer of the medication where they keep the over-flow of medication blister packets to see if they had a blister packet for Sucralfate 1 GM for resident #30. Medication Aide N reported she had not found the blister packet for Sucralfate 1 GM to administer as ordered at 12:00 PM. Medication Aide N reported she had administered the last dose of the Sucralfate 1 GM in AM and did not have the medication on hand to administer the 12:00 PM dose as ordered. The Medication Aide stated, The facility recently changed to a new pharmacy, and we have been having problems with medication refills not being delivered on time. That is why we do not have the Sucralfate 1 GM for Resident #30. The blister packets have a blue line on the last row that alerts the staff that it is time to re-order the medication. I re-ordered the Sucralfate 1 GM, but it is still pending delivery. In an interview on 03/13/24 at 3:52 PM, with the DON she reported the Medication Aide N had reported to her today, that they were having problems with the new vendor pharmacy not sending medication refills on a timely basis. The DON stated that she was not aware that the pharmacy was not sending medication refills on a timely basis until today. The DON reported the blister packets had a blue line on the last row that alerts the staff that it is time to re-order the medication. Resident #29 Review of Face Sheet dated 03/14/24 at 4:32 PM for Resident #29 revealed admitted : 05/17/18; readmitted [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of History & Physical dated 02/07/24 for Resident #29 revealed [AGE] year-old female with diagnoses of pulmonary fibrosis (scarring and thickening of the tissue around and between the air sacs called alveoli in the lungs, these changes make it harder for oxygen to pass into the bloodstream) and chronic obstructive pulmonary disease. Review of Quarterly MDS dated [DATE] for Resident #29 revealed Active Diagnoses: COPD, Respiratory Failure, and Oxygen. Record Review 03/14/24 of Physician Orders dated March 2024 for Resident #29 revealed IPRAT-ALBUT 0. 5 (2.5) mg/3 ml, give one vial via inhalation four times a day. Document resident lung sounds pre and post respiratory treatment. Document resident lung O2 (oxygen) saturation pre and post respiratory treatment. Document resident pulse pre and post resp. TX (treatment) , document number of minutes spent at bedside pre and post resp. TX. Document respirations pre and post Resp. TX. Diagnosis: Chronic respiratory failure with hypoxia. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #29 revealed IPRAT-ALBUT 0.5 (2.5) mg/3 ml (about 0.1 oz), give one vial via inhalation four times a day at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Document resident lung sounds pre and post respiratory treatment. Document resident lung O2 saturation pre and post respiratory treatment. Document resident pulse pre and post resp. TX, document number of minutes spent at bedside pre and post resp. TX. Document respirations pre and post Resp. TX. Diagnosis: Chronic respiratory failure with hypoxia. Nurse documented on 03/11/24 at 4:00 PM Pre-Treatment: O2 sats (oxygen saturation)98, pulse 64, respiration 18, Resp Min (respirations per minute) 15, Lug Snds (lung sounds)- See Details Report for SR Details; Post Treatment O2 sats 96, pulse 62, respiration 18, Resp Min 15; Lug Snds - See Details Report for SR Details. The state surveyor requested Resident #29 ' s Detail Report for SR Details from medical records on 03/14/24 to review pre and post notes related to nurse checking lung sounds. Report was not provided prior to exit. In a medication pass observation and interview with LVN O on 03/11/24 at 3:12 PM, he stated he was going to give Resident #29 a nebulizer treatment with Ipratropium Bromide & Albuterol Sulfate 0.5 mg & 3 mg/ 3 ml (about 0.1 oz) vial. The nurse entered the room, did not wash hands and/or use hand sanitizer. He poured medication into nebulizer cup, checked oxygen saturation prior to starting treatment. He stated the oxygen saturation was at 98% prior to administration of nebulizer treatment. It was observed that the nurse did not check pulse, or lungs sounds before the treatment. The Nebulizer treatment was completed at 3:34 PM. The nurse checked his oxygen saturation after treatment and was at 95%. The nurse did not check his pulse, or lung sounds after treatment was completed. In an interview with LVN O on at 3:36 PM reported the nurses had been trained to check pulse, lung sounds, and check oxygen saturation before & after treatment. Resident #51 Review of Face Sheet dated 03/14/24 at 12:17 PM for Resident #51 revealed admitted : 02/22/22; readmitted [DATE]. (continued on next page)

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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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of History & Physical dated 03/06/24 for Resident #51 revealed [AGE] year-old male with diagnoses of vascular dementia, prior CVA (cerebral vascular accident) hemiparesis affecting left side, hypertension, chronic renal disease stage 4, DM (diabetes mellitus)Type 2, and atrial Fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow). Review of Quarterly Review assessment dated [DATE] for Resident #51 Active Diagnoses: Coronary Artery Disease, CVA with hemiparesis affecting left side, and hypertension. Record Review on 03/14/24 of the Physician Orders dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 12/01/23 and 12/28/23 included Resident #40. Review of Consultant Pharmacist's Medication Regime Review for Resident #40 dated 01/01/2024 and 01/29/24 did not document any recommendations to take Spironolactone with food. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 02/1/24 and 02/26/24 included Resident #40. Medication Pass Observation with Medication Aide P revealed blood pressure was checked prior to medication administration. B/P (blood pressure) 120/61 and Pulse 63. Medication Aide P stated she was going to administer Hydralazine 50 mg 1 tablet by mouth tid. Hold for SBP (systolic blood pressure) <110 or DBP<60 and Carvedilol 25 mg one tablet two times a day. Hold for SBP (systolic blood pressure) <100 or DBP <60 or Heart Rate <60. Medication was administered at 3:17 PM. Observation on of Medication Blister Packet Pharmacy Label documented: Carvedilol 25 mg one tablet two times a day. Hold for SBP <100 or DBP <60 or Heart Rate <60. Take with food. Telephone interview on 03/14/24 at 1:36 PM with the Pharmacist revealed she was one of the pharmacy consultants and stated that the pharmacy consultant assigned to the facility was on leave. The Pharmacist reported that the dispensing pharmacist will add auxiliary labels to a dispense medication package in addition to the usual prescription label that contained warnings, dietary information, administration instructions or cautionary details to administer medications. The pharmacy consultant assigned to the facility should alert the attending physician of the auxiliary label alerts to revise physician's orders as needed to administer the medication according to manufacturer's specifications to take medication with food. The Pharmacist stated, that in the case of Resident #51, the pharmacy consultant should have made a recommendation during Monthly Medication Regime Reviews to make a recommendation to the attending physician to change the order to administer the Carvedilol 25 mg one tablet two times a day with food according to manufacturer's specifications. Resident #40 Review of Face Sheet dated 03/14/24 at 4:34 PM for Resident #40 revealed admitted : 09/20/17; readmitted [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of History & Physical dated 05/24/23 for Resident #40 revealed [AGE] year-old female with diagnoses of hypertension and dementia. Review of Annual MDS dated [DATE] for Resident #40 revealed Active Diagnoses: heart failure and hypertension. Record Review on 03/14/24 of the Physician Orders dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 12/01/23 and 12/28/23 included Resident #40. Review of Consultant Pharmacist's Medication Regime Review for Resident #40 dated 01/01/2024 and 01/29/24 did not document any recommendations to take Spironolactone with food. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 02/1/24 and 02/26/24 included Resident #40. An observation on 03/13/24 at 3:20 PM revealed during the medication pass observation with Medication Aide P, she stated she was going to administer Spironolactone 25 mg give one tablet by mouth bid. Observed the pharmacy label documented: Take with food or milk. Medication was administered at 4:11 PM. Observation on of Medication Blister Packet Pharmacy Label documented: Spironolactone 25 mg give one tablet by mouth bid. Take with food. Controlled Drugs: 200 Hall: An observation and interview on 03/11/24 at 9:09 AM with LVN O revealed that he was working from 6 AM to 6 PM and had already signed the Controlled Drugs-Count Record at 6:00 PM prior to counting controlled drugs with on-coming nurse at change of shift. LVN O stated, I already signed off before counting controlled drugs with the on-coming nurse at change of shift because I am going to be here until 6:00 PM. We have been trained to count controlled substances with the on-coming and off-going nurse at change of shift. Then we signed the Controlled Drugs-Count Record if the counts are correct. 300 Hall: In an interview and record review on of Controlled Drugs-Count Record with LVN Q revealed blanks in documentation on 03/10/24 for the 6A-6P on-coming nurse and 6a-6p off-going nurse. LVN Q stated The nurses had been trained to count controlled substances with the on-coming and off-going nurse at change of shift. If the count is correct then we sign the Controlled Drugs-Count Record. Medication Carts: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Medication Cart 400 Hall: Observation on at 3:11 PM with LVN B revealed a 16 oz (ounce) bottle of Geri-Tussin stored in medication cart had dried drippings on the neck of the bottle. LVN B stated they had been trained to keep medication bottles free of drippings. Medication Cart 300 Hall: Observation on at 3:25 PM with Medication Aide P revealed a 6 oz bottle of Geri-Tussin stored in the medication cart and it had dried drippings on the neck of the bottle. Medication Aide P stated they had been trained to keep medication bottles free of drippings. Medication Cart 200 Hall: Observation at 3:31 PM with LVN R revealed 6 oz bottle of Geri-Tussin (cough/cold medication) stored in medication cart had dried drippings on neck of bottle. LVN R stated they had been trained to keep medication bottles free of drippings. Review of facility's undated policy & procedure on Pharmacy Services provided by the DON on 03/13/24 revealed: Policy-The facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist. Policy Interpretation and Implementation: The licensed Pharmacist shall collaborate with facility leadership and staff to coordinate pharmacy services within the facility and guide the development and implementation of pharmacy services procedures. The facility shall contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support resident's needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility and Medical Director to: Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services (including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility. Help the facility assure that medications are requested, received, and administered in a timely manner as ordered by authorized prescribers. Help establish procedures for conducting the monthly medication regime review (MRR) for each resident in the facility. Help develop procedures and guidance regarding when to contact a prescriber about a medication issue. Help the facility develop procedures and evaluate pharmacy services related to delivery and storage systems within the facility; to minimize loss of or tampering with the medication supplies; and to identify corrective actions for problems related to pharmacy services and medications, including recommended current resources to help staff to understand and identify medications and related information such as contraindications, adverse consequences, and appropriate monitoring. Review of facility's policy & procedure on Medication Labels dated 09-2018; Revision Date: 08-2020 revealed: Policy-Medications are labeled in accordance with facility requirements and state and feral laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels. Each prescription medication label includes Auxiliary labels indicating storage requirements and special procedures, such as Shake well', or Refrigerate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of facility's undated policy & procedure on Controlled Substance provided by the DON on 03/13/24 revealed: Policy Statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substance. Review of Facility's undated Policy on Administering Medications through a Small Volume (Handheld) Nebulizer provided by DON on 03/12/24 revealed: Purpose: This procedure's purpose is to administer safely and aseptically aerosolize medication particles into the resident's airway. Steps in the Procedure: Wash & dry hands. Obtain baseline pulse, respiratory rate, and lung sounds. Wash and dry hands. Dispense medication into nebulizer cup. Approximately five minutes after treatment begins (or sooner if clinical judgement indicates) obtain the resident's pulse. Monitor for medication side effects, including rapid pulse, restlessness, and nervousness throughout the treatment. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. When the treatment is complete, turn off the nebulizer, and disconnect the T-piece, mouthpiece, and medication cup. Wash & dry hands. Obtain post-treatment pulse, respiratory rate, and lung sounds. Rinse the nebulizer equipment after use. Wash & dry hands. Review of facility's undated policy & procedure on Administering Medications provided by the DON on 03/11/24 revealed: Policy Statement-Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation-The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with orders, including any required time frame. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate on the MAR for that drug and dose. Attending Physician must also be notified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observations, interviews, and record review, the facility failed to ensure that irregularities identified by reviews of resident's drug regimens by a licensed pharmacist were reported to the attending physician, the facility's medical director, and director of nursing, and that these reports were acted upon for 2 (Resident #51 & 40) of 14 residents whose drug regimens were reviewed. The consulting pharmacist failed to act upon the dispensing pharmacist recommendations to administer prescribed medications according to manufacture specifications. This failure placed residents at risk of not receiving medications according to manufacturer specifications placing them at increased risk of adverse drug effects and decline in their health status. The findings included: Resident #51 Review of Face Sheet dated 03/14/24 at 12:17 PM for Resident #51 revealed admitted : 02/22/22; readmitted [DATE]. Review of History & Physical dated 03/06/24 for Resident #51 revealed [AGE] year-old male with diagnoses of vascular dementia, prior CVA hemiparesis affecting left side, hypertension, chronic renal disease stage 4, DM Type 2, atrial Fibrillation. Review of Quarterly Review assessment dated [DATE] for Resident #51 Active Diagnoses: Coronary Artery Disease, CVA with hemiparesis affecting left side, hypertension. Record Review 03/14/24 of Physician Orders dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 12/01/23 and 12/28/23 included Resident #40. Review of Consultant Pharmacist's Medication Regime Review for Resident #40 dated 01/01/2024 and 01/29/24 did not document any recommendations to take Spironolactone with food. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 02/1/24 and 02/26/24 included Resident #40. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Medication Pass Observation with Medication Aide P revealed blood pressure was checked prior to medication administration. B/P 120/61 and Pulse 63. Med Aid stated she was going to administer Hydralazine 50 mg 1 tablet by mouth tid. Hold for SBP<110 or DBP<60 and Carvedilol 25 mg one tablet two times a day. Hold for SBP <100 or DBP <60 or Heart Rate <60. Medication was administered at 3:17 PM. Review of Medication Blister Packet Pharmacy Label documented: Carvedilol 25 mg one tablet two times a day. Hold for SBP <100 or DBP <60 or Heart Rate <60. Take with food. Telephone interview on 03/14/24 1:36 PM with Pharmacist revealed she was one of the pharmacy consultants and stated that the pharmacy consultant assigned to facility was on leave. Pharmacist reported that dispensing pharmacist will add auxiliary labels to a dispense medication package in addition to the usual prescription label that contain warning, dietary information, administration instructions or cautionary details to administer medications. The pharmacy consultant assigned to the facility should alert the attending physician of the auxiliary label alerts to revise physician's orders as needed to administer the medication according to manufacturer's specifications to take medication with food. Pharmacist stated, that in the case of Resident #51, the pharmacy consultant should have made a recommendation during Monthly Medication Regime Reviews to make a recommendation to the attending physician to change the order to administer the Carvedilol 25 mg one tablet two times a day with food according to manufacturer's specifications. Resident #40 Observation on 03/13/24 3:20 PM during Medication Pass Observation with Medication Aide P stated she was going to administer Spironolactone 25 mg give one tablet by mouth bid. Pharmacy Label documented: Take with food or milk. Medication was administered at 4:11 PM. -Review of Medication Blister Packet Pharmacy Label documented: Spironolactone 25 mg give one tablet by mouth bid. Take with food. Review of Face Sheet dated 03/14/24 at 4:34 PM for Resident #40 revealed admitted : 09/20/17; readmitted [DATE]. Review of History & Physical dated 05/24/23 for Resident #40 revealed [AGE] year-old female with diagnoses of hypertension, dementia. Review of Annual MDS dated [DATE] for Resident #40 revealed Active Diagnoses: heart failure, hypertension. Record Review 03/14/24 of Physician Orders dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Record Review 03/14/24 of Medication Administration Record dated March 2024 for Resident #40 revealed Spironolactone 25 mg give one tablet by mouth bid. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 12/01/23 and 12/28/23 included Resident #40. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Consultant Pharmacist's Medication Regime Review for Resident #40 dated 01/01/2024 and 01/29/24 did not document any recommendations to take Spironolactone with food. Review of Consultant Pharmacist's Medication Regime Review: Listing of Residents Reviewed with No Recommendations dated 02/1/24 and 02/26/24 included Resident #40. Review of Pharmaceutical Services Contract dated 02/01/24 revealed: During each month, the Pharmacy shall review computer generated Order Sheet, Medication Administration Records for accuracy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review the facility failed to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 3 (Resident #65, Resident #24, and Resident #51) of 5 residents reviewed for unnecessary medications. Resident #65 was prescribed Seroquel/quetiapine (an antipsychotic) to treat depression. Resident #51 was prescribed Olanzapine (an antipsychotic) to treat major depression. Resident #24 was prescribed Seroquel/quetiapine (an antipsychotic) to treat restlessness and agitation. This failure put residents at unnecessary risk of side effects from psychotropic medications. Findings included: Resident #65 Record review of Resident #65 ' s face sheet dated 03/14/2024 revealed she was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #65 ' s History and Physical dated 05/24/2023 revealed she had a past medical history of Alzheimer ' s dementia with psychosis. She was assessed as having Major depressive disorder, recurrent episode. Treatment plan included to continue Seroquel [brand name for quetiapine] for Major depressive disorder. Record review of Resident #65 ' s quarterly MDS dated [DATE] revealed she had a BIMS score of 6 (severe cognitive impairment). She had symptoms of delirium (disturbance in mental abilities resulting in confused thinking) including intermittent confused thinking. She did not have symptoms of depression or psychosis. Her diagnoses included Alzheimer ' s disease, non-Alzheimer ' s dementia, anxiety disorder, depression, and psychotic disorder other than schizophrenia. She had been taking antipsychotic, antianxiety, and antidepressant medications. Antipsychotics were received on an ongoing basis. It was noted that a GDR had been attempted on 09/08/2023. Record review of Resident #65 ' s 5-Day MDS dated [DATE] revealed she had a BIMS of 8 (moderate cognitive impairment). She had symptoms of delirium (disturbance in mental abilities resulting in confused thinking) including intermittent confused thinking. She did not have symptoms of depression or psychosis. Her diagnoses included Alzheimer ' s disease, non-Alzheimer ' s dementia, anxiety disorder, depression, and Psychotic disorders other than schizophrenia. She had been taking antipsychotic, antianxiety, and antidepressant medications. No issues were found during drug review. (continued on next page)

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F 0758 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 #65 ' s care plans revealed a care plan dated 12/13/2023 for Seroquel (quetiapine). The care plan stated she was at risk for side effects, with a goal that she would have no injury related to antipsychotic medication usage/side effects daily and ongoing over the next 90 days. Record review of Resident #65 ' s physician ' s orders dated 12/15/2023 revealed that she was to receive one 25 MG tablet of quetiapine fumarate (Seroquel) each day to treat major depressive disorder, recurrent, unspecified. Record review of Resident #65 ' s physicians ' note dated 02/21/2024 revealed the assessment identified diagnoses included Alzheimer ' s disease and Other recurrent depressive disorders. 25 MG of Quetiapine was to be continued for dementia. Buspirone and Escitalopram Oxalate were to be continued for recurrent depressive disorder. Record review of Resident #65 ' s physician ' s progress note dated 01/10/2024 revealed that she was to continue to receive one quetiapine fumarate 25 MG tablet at bedtime for dementia associated with other underlying disease, with agitation, unspecified dementia severity. Record review of Resident #65 ' s physician ' s progress note dated 02/21/2024 revealed that she was to continue to receive one quetiapine fumarate 25 MG tablet at bedtime for dementia associated with other underlying disease, with agitation, unspecified dementia severity. Record review of Resident #65 ' s MAR for February 2024 revealed she was administered one 25 MG tablet of quetiapine fumarate (Seroquel) daily. Record review of Resident #65 ' s MAR for March 2024 (accessed 3/12/2023) revealed she was administered one 25 MG tablet of quetiapine fumarate (Seroquel) daily from 03/01/2024 through 03/11/2024. In an interview on 03/14/2024 at 3:11 PM the DON revealed that Major depressive disorder was an appropriate indication for administration of quetiapine. In an interview on 03/14/2024 at 3:14 PM in an interview MDS Nurse H revealed that she was not familiar with the risks associated with quetiapine. She said that she communicated with the physicians to find out about the match between medications and diagnoses, and that if there were changes in medications, she communicated these to the DON. She stated that she was not responsible for determining if a particular medication was indicated for a particular diagnosis. Multiple attempts were made to communicate with Resident #65 ' s physician, but a return phone call was not received prior to exiting the facility. Resident #51 Record Review of Resident #51 Administration Record start date 08/25/2023, revealed the assessment identified diagnosis included Major Depression, recurrent, mild. Olanzapine 2.5 MG is used for an antipsychotic medication. (continued on next page)

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F 0758 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 #51 ' s Quarterly MDS dated [DATE] has a BIMS score of 6 (Severe cognitive impairment) he did not have any symptoms of delirium. His diagnosis included Alzheimer's disease, Anxiety Disorder, Depression, Psychotic Disorder, and Schizophrenia. It was noted that a GDR had been attempted on 08/02/2023. He had been taking an antipsychotic, antianxiety. No issues were found during the drug review. Record review of Resident #65 ' s care plans revealed a care plan dated 11/18/2022 for Olanzapine. The care plan stated he was at risk for side effects, with a goal that she would have no injury related to antipsychotic medication usage/side effects daily and ongoing over the next 90 days. In an interview on 03/14/2024 at 03:14 pm, the DON stated she was not responsible for determining if a particular medication was indicated for a particular diagnosis, that it would be the MDS Nurse H. The DON was asked if she knew what Seroquel or Olanzapine were treated for, and she stated she did not know. She would have to search it and was not familiar with any antipsychotic modifications. The DON provided a phone number to MDS Nurse H, as she was out for the day. An interview was attempted with MDS Nurse H via telephone on 03/14/2024 at 04:15pm, voicemail was left as she did not answer. Resident #24 Record Review of Resident #24 face sheet dated 03/14/2024, revealed she was [AGE] years old, who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #24 ' s History and Physical dated 05/12/2023 revealed she had a past medical history of Alzheimer ' s, dementia, and Vascular Dementia. She was assessed as having behavior present, fluctuates (comes and goes, changes in severity). Record review of Resident #24 ' s quarterly MDS dated [DATE] revealed she had a BIMS of 4 (Severe cognitive Impairment) She had symptoms of delirium (behaviors present, fluctuates). She did not have symptoms of depression or psychosis. Her diagnoses included Alzheimer ' s disease, non-Alzheimer ' s dementia, anxiety disorder, depression. She had been taking an antipsychotic, and antidepressant medications. Antipsychotics were received on a routine basis. It was noted that a GDR was not attempted. Record review of Resident #24 ' s care plans revealed a care plan dated 11/16/2023 for Seroquel (quetiapine). The care plan stated she was at risk for side effects, with a goal that she would have no injury related to antipsychotic medication usage/side effects daily and ongoing over the next 90 days. Record review of Resident #24 ' s physicians ' note dated 11/16/2023 revealed the assessment identified diagnoses included Restlessness and Agitation. 25 MG of Quetiapine was to be given one tablet by mouth twice daily. (continued on next page)

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

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 03/14/2024 at 03:14 pm, the DON stated she was not responsible for determining if a particular medication was indicated for a particular diagnosis, that it would be the MDS Nurse H. The DON was asked if she knew if Seroquel or Olanzipine were treated for, she stated she did not know. She would have to search it and was not familiar with any antipsychotic modifications. The DON provided a phone number to MDS Nurse H, as she was out for the day. In an interview on 03/14/2024 at 04:45pm, the DON stated a GDR was not done for Resident #24 because the antipsychotic was started by hospice on 11/16/2023. Multiple attempts were made to communicate with Resident #65 ' s physician, but a return phone call was not received prior to exiting the facility. An interview was attempted with MDS Nurse H via telephone on 03/14/2024 at 04:15pm, voicemail was left as she did not answer. Record review of the facility policy revealed when a resident participates in the hospice program, a coordination plan of care between the facility, hospice agency, and residents/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. Record review of the facility policy Antipsychotic Medication Use revised 4/2007 revealed that antipsychotic medication would be used only when necessary to treat a specific condition. Conditions/diagnoses for which antipsychotics could be prescribed included: depression with psychotic features, and treatment refractory major depression; or for dementing illness with associated behavioral symptoms. Record review of the website drugs.com on 03/19/2024 revealed that Seroquel (quetiapine) was used to treat schizophrenia or in patients with bipolar disorder. Quetiapine may increase the risk of death in older adults with mental health problems related to dementia. Olanzapine is an antipsychotic medication used to treat psychotic conditions such as schizophrenia and bipolar disorder. Drugs.com had a warning that olanzapine is not approved for use in older adults with dementia-related conditions and may increase the risk of death in older adults with dementia-related psychosis and is not approved for this use.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

20026

Based on observations, interviews, and record reviews the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation and food storage.

-The facility failed to keep 2 bottles of Dessert Sauce stored on a metal rack in the dry storage room free of dried drippings around the lids.

-The facility failed to keep a plastic bottle of Baking Soda free of white residual around sides of bottle.

-The facility failed to keep a gallon of Vanilla, a gallon of Soy Sauce, a gallon of Worcestershire Sauce, and a gallon of Imitation Maple Syrup Sauce stored on metal storage rack in the dry storage room free of grease build up, white powder residual, and dried dripping on sides of containers.

-The facility failed to discard perishable foods stored, in the dry storage area. Potatoes were wrinkled, soft to touch, mushy, and sprouting.

-The facility failed to store an opened box of Corn Starch in a sealed container.

-The facility failed to store foods in the refrigerator in sealed containers.

-The facility failed to maintain the ice machine in operational condition.

-The facility failed to ensure Puree foods were prepared in sanitary conditions.

-The facility failed to maintain air vents free of rust and ceiling free of chipped paint.

These failures could affect residents by placing them at risk of food borne illnesses.

Findings included:

Metal Rack #1:

-Observation on at 8:20 AM, with the Cook revealed 2 bottles of Dessert Sauce had dried drippings around the lids.

-36 OZ Bottle of Baking Soda had white residual around sides of bottle directly below the lid of the bottle.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observation on at 8:21 AM, with the Cook revealed 1 plastic Gallon of Vanilla had grease build up, white powder residual, and dried dripping on sides of container; 1 plastic Gallon of Soy Sauce had white powder residual and dried dripping on sides of container; 1 plastic Gallon of Worcestershire Sauce had dried dripping and white powder residual on sides of bottle on sides of container; 1 plastic Gallon of Imitation Maple Syrup Sauce had dried dripping on sides of container. An opened box of Corn Starch was not stored in a sealed container. Metal Rack #2: -Observation on at 8:23 AM, with the Cook revealed a large white plastic container stored on the bottom shelf of a metal rack that contained potatoes that were soft to the touch, wrinkled, and sprouting. In an interview on 03/11/24 at 8:46 AM with the Dietary Manager she stated, dietary staff had been trained to clean food containers after each use, prior to placing them on storage racks in the dry storage room, and opened food containers must be stored in sealed plastic bags and/or wrapped in sealed plastic wrap when stored in dry storage and/or refrigerators. Refrigerators/Freezer: Refrigerator #1: -Observation on 03/11/24 at 8:31 AM, with the Cook revealed one opened 16 OZ container of Margarine that was opened and covered with plastic wrap that was not sealed; a large, squared plastic container that contained Green Chile dated 03/04-03/10 was covered with Aluminum Foil wrap was not sealed; a large, squared plastic container that contained Beans was not sealed. Refrigerator #2: -Observation on 03/11/24 at 8:27 AM, with the Cook revealed a glass dinner plate that contained a sandwich dated 03/09/23-03/15/23 was covered with plastic wrap and was not completely sealed. The Cook stated, I did not know that the plastic wrap had to be completely sealed. That is how we do it often. -Observation on at 8:28 AM, with the Cook revealed a large plastic container that contained shredded cheese dated 3/10/24 had a cracked lid and was not completely sealed. Refrigerator #3: -Observation on 03/11/24 at 8:27 AM, with the Cook revealed 2 large metal cookie sheets that contained sausage patties and bacon slices were covered with brown paper and not sealed. Cook stated, I did not know that the cookie sheets needed to be wrapped and completely sealed. Ice Machine: (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Observation on 03/11/24 at 8:36 AM, with the Cook revealed the ice machine had white calcium build-up inside on right side of ice machine and rusted areas were the hinged plastic door closed. It was observed that there was white calcium build up and rust around the bottom of the ice machine. The Cook reported that the ice machine was cleaned once a month.

Observation and interview on 03/13/24 at 1:22 PM, with the Dietary Manager demonstrated to surveyor that the ice machine had been leaking water from the ice maker that drips directly into the ice bin. She stated, This has been going on for approximately 6 months. That is what is causing the white calcium build-up and rust inside on the right side of the ice machine, where the water is leaking, and calcium build up down the sides and bottom of the ice machine, and on the tile floor around the ice machine. The Administrator and the Maintenance Director are aware that the ice machine has been leaking water for 6 months and are pending an approval on a quote to replace the ice machine. It was observed that the vent on the ice machine had a copious amount of light gray lint.

Pureed Food Preparation:

Observation on 03/11/24 at 8:28 AM, with the Dietary Manager revealed a squared metal pan that contained water had 3 large potatoes and potato peels were in the sink next to the food preparation table. There were white stains on the bottom of the sink. The Dietary Manager stated it was the starch from the potatoes when the cook had peeled the potatoes in the sink.

-Observation on 03/11/24 at 11:15 AM, with the Dietary Manager revealed the Cook had cut six 3-ounce slices of pork loin and had added meat juice in a squared metal container to puree the meat using a handheld blender stick. The Cook placed the metal container in the sink that was next to the food preparation table to puree the meat. There was a squared metal container in the sink that contained meat juice in the same sink, potato peeling, white residual, and water residual in the sink. It was observed that there were food particles and water residual in the sink. The cook added 3 1/2 cups of chicken broth to the meat mixture and continued to puree the meat. The cook said the meat was at the correct consistency; she removed the metal container from the sink and placed it in the steam table serving line.

-Observation on 03/11/24 at 11:20 AM, with the Dietary Manager revealed the Cook placed 6 scoops of buttered noodles using a #10 scoop in a squared metal container to puree the noodles using a handheld blender stick. The Cook placed the metal container in the sink that was next to the food preparation table to puree the noodles. Cook added 1 cup of chicken broth to noodle mixture and continued to puree the noodles. The Cook stated that the noodles were at the correct consistency, she removed the metal container from the sink and placed it in the steam stable serving line.

-Observation on 03/11/24 at 11:30 AM, with the Dietary Manager revealed the Cook placed 6 scoops of cooked spinach using #10 scoop in a squared metal container to puree the spinach using a handheld blender stick. The Cook placed the metal container in the sink that was next to the food preparation table to puree the Spinach. Cook added 1 1/2 cups of chicken broth to Spinach mixture and continued to puree the spinach. The cook said the spinach was at the correct consistency; she removed the metal container from the sink and placed it in the steam stable serving line.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observation on 03/11/24 at 11:35 AM, with the Dietary Manager revealed the Cook placed three 2 lb. bags of squash in a squared metal container to puree the squash using a handheld blender stick. The Cook placed the metal container in the sink that was next to the food preparation table to puree the squash. The Cook added 2 cups of milk, half a cup of butter, six cups of chicken broth, and 1/2 cup of food thickener to squash mixture to puree the squash. The cook said the squash soup was at the correct consistency; she removed the metal container from the sink and placed it in the steam stable serving line. -Interview and record review on 03/13/24 at 1:01PM with the Dietary Manager stated the Cook should not place the metal container in the sink that was next to the food preparation table to puree food. The food should be prepared on the food table and not in the sink used to wash vegetables. Environmental Check in Kitchen: Observation on 03/13/24 at 1:23 with the Dietary Manager revealed rusted vent covers throughout the kitchen; wall by refrigerator # had dark yellow color substance on wall where a paper had been removed; ceiling had chipped paint directly in front of the Dietary Manager's office. Review of facility's policy on Food Storage revised June 01, 2019, provided by the Dietary Manager on 03/13/24 revealed: Policy-To ensure all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Procedures: Dry storage rooms-To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. Where possible, leave items in the original cartons placed with the date visible. Refrigerators: Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Food Code 2022 (C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. 3-202.15 Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 20026 Based on the observations, interviews, and record review the facility failed to dispose of garbage and refuse properly for 2 (Dumpsters #1, & #2) of 2 dumpsters reviewed for food safety requirements. -The facility failed to keep one of two plastic lids covered on Front Load Dumpster, making trash placed in dumpster visible. - The facility failed to keep the side metal door cover close on Side Load Dumpster, making trash placed in dumpster visible. This failure could place residents at risk of unsanitary conditions and risk for exposure to germs and diseases carried by insects and rodents. Findings included: Observation on 03/14/24 at 5:39 PM revealed Front Load Dumpster #1, half uncovered; there were cardboard boxes and plastic bags full of waste in dumpster; Side load dumpster was partially opened. Interview on 03/14/24 at 5:40 with the Maintenance Director revealed front door dumpster was used by the nursing department and side load dumpster was used by dietary staff. He stated that dumpsters should always be kept covered to prevent insects and rodents from getting into the dumpsters. Review of facility's policy on Garbage Receptacles revised on June 1, 2019, provided by Maintenance Director on 03/14/24 revealed: Policy: The facility will maintain garbage receptacles in a clean and sanitary manner to minimize the risk of food hazards. Outdoor receptacles: Outdoor storage surface for refuse shall be constructed of nonabsorbent material such as concrete or asphalt and shall be smooth, durable, and sloped to drain. It shall be constructed to have tight fitting lids, doors or covers and stored in a manner that is inaccessible to insects and rodents with doors/lids kept closed and no waste outside of the receptacle. All shall be maintained in good repair. Refuse shall be removed from the premises at a frequency that will minimize the development of objectionable odors and attract insects and rodents.

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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)

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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)

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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 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	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of El Paso	10880 Edgemere Blvd El Paso, TX 79935

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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 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)

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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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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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 43871 49850 Based on interviews and record review the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 3 (Resident #24, Resident #30, and Resident #61) of 21 residents reviewed for accuracy and completeness of clinical records. The facility failed to completely and accurately discontinue order provided to Resident #24 for puree diet. The facility failed to accurately document Resident #61 ' s allegation of a slap on the hand from the Administrator on her medical records. The facility failed to accurately document Resident #30 ' s use of her physician-ordered CPAP machine. These failures put residents at risk of not containing the proper nutrition's needed for a hospice patient, at risk of staff being unaware of resident ' s pattern of refusal of CPAP treatments, and at risk of staff being unaware of resident ' s allegations of abuse. Findings included: Resident #24 Record review of Resident #24 ' s face sheet dated 03/13/2024 revealed she was a [AGE] year-old female and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #24 ' s History and Physical dated 03/13/24 revealed she had a diagnosis of unspecified protein-calorie malnutrition. A condition which refers to a nutritional status in which reduced availability of nutrition leads to changes in the body composition and function. Orders included Resident # 24 be on a puree diet dated 01/24/2024, and a start date order on 01/30/2024 for a regular texture/thin liquid fortified meals. In an interview on 03/12/24 at 10:42 am the Dietitian revealed weekly weights were done every Friday. Weekly weights triggered 4 residents this week. Resident #24 was not triggered. When they were on hospice care they stop taking the resident's weight. So, there was no weight on her. She had no orders for the milkshake. The dietitian would be the one to be notified of residents that do not eat. No one has asked to put her on a supplement. Resident #24 was on fortified meals which contains cereal, oatmeal, and soup (which they add extra cream and add more calories to gain a little more weight). That would be presented on the ticket when the meal was served. The CNA's were supposed to report it to the dietary manager. It has not been reported that she has not been eating her meals. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review on 03/12/24 at 11:32 am, shows progress note stated Resident #24 did not eat her meal. In an interview on 03/12/24 at 12:32 pm, Dietary Manager stated that the Nurses will send a dietary slip and then it will be placed in the system. If I am not here, it will be someone else. The is only if told by the nurse. If there is a fallout, then that should be the nurse's responsibility. Sometimes she does eat, and I observe that she does not eat but the nurse says she's hospice, I do offer in the dining room, but she likes to drink milk shakes and she will eat a sandwich from time to time, and we cut it for her. I have not seen any CNA offer her anything regarding a shake. It is whenever she requests them, not all the time because she gets tired of them. Since it is the resident food preferences it is okay that she only gets it when she wants it. In an interview on 03/12/24 at 03:25 pm, the DON revealed that usually the speech therapist will give the DON/Nurses the okay to change the orders to puree and then the nurses can downgrade it. A dietary slip will be filled out and given to the dietary team and the meal will be changed. Once the order was received from the doctor, the facility notified the family and updated it in the system. The Dietitian will update their system because they use a different system than nurses do and then nursing will do it on their end. Any changes in diet need to be notified by a white/yellow slip and scanned into the resident's profile. As far as hospice patients, it is the same process, with any resident. Everything was scanned into the resident's chart. The DON looked into resident #24 ' s orders and stated that her chart was not updated and discontinued the puree orders while interview was taking place. The order for regular texture start date of 01/30/2024 was the only order active. DON stated she will do an in-service following discontinued orders. Record review of the facility policy revealed when a resident participates in the hospice program, a coordination plan of care between the facility, hospice agency, and residents/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. Resident #61 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, which means her cognition was intact. Record review of Resident #61 ' s care plan dated 1/16/24 revealed Resident #61 had history of false accusations, critical of staff and has expressed verbally aggressive behavior. (continued on next page)

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F 0842 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 1/26/24 and signed by SW on 1/26/24 revealed 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. [Resident 61] verbalized she did not want to moved 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 a different room; Administrator and SW discussed, and administrator identified a room as available for resident to go into private room. [Resident #61] was notified she would go into private room and verbalized no concern. Niece then appeared in hallway and SW and administrator spoke with niece to inform her of events that transpired. 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 verbalizing dissatisfaction with the room change and how the situation was handled by the facility. Resident #61 ' s family member stated how chaotic she remembered the situation being when she arrived. The administrator explained the situation that transpired and Resident #61 ' s family member stated 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 the staff. [Resident #61] then spoke to the Administrator and notified him that she was scared of him and that he has forcefully moved her to room. [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 he removed the hand from the wall. In previous conversations with the resident, she had stated the Administrator had forced her out of the hallway but did not mention it being a physical matter. [Resident #61] had also stated that she felt as if SW would side with the Administrator. SW clarified that she always had the resident ' s best interest as priority. The Ombudsman also verbalized requiring a written notice and advance notice of room change. The Administrator reported that change was done to avoid further escalation of confrontation. [Resident #61] remained in the 100 hall. Family was to be notified of any and all changes with resident and all aspects of care. (continued on next page)

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F 0842 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 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 Ms. [NAME] said the night before and administrator kick her out of her room. 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 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. She continues to state 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. [Resident #61] ' s family member was in the meeting and her niece was in the meeting with the Social worker as well. 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)

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F 0842

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 10:00 am, Resident #61 was alert and oriented to person, place, time, and event. Resident #61 stated she was moved rooms a 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 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 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 attempt to resist 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.

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. The call was not returned by the time of survey exit.

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 ' s 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 it to State Office.

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 the 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 made arrangements 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 they had discussed the room change in which Resident #61 had voiced the Administrator had forced her out of the room by pushing her with the wheelchair. The SW stated she was not in the room when the Administrator had assisted Resident #61 to be removed from the room. The SW stated 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.

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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 0842 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 3:43 pm, the Administrator stated Resident #61 had a room change back in January 2024 due to complaints from roommate family of her being verbally aggressive. The Administrator stated he had discussed the room change with Resident #61 and had agreed to the change. The Administrator stated Resident #61 had changed her mind when she saw staff assisting her with moving belongings. The Administrator stated a meeting was held with the Ombudsman, SW, Resident #61, and her family member, but could not recall the date. The Administrator stated during the meeting Resident #61 had stated he had hit her. The Administrator stated the Maintenance Director, and the SW were present in the room when he had assisted Resident #61 out of the room. 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. During an interview on 3/13/24 at 3:39 pm, the DON stated she was not present in the meeting that was held with the Ombudsman regarding Resident #61 ' s allegations. The DON stated that if the allegation was made, it was expected for that to be documented on Resident #61 ' s clinical records. The DON stated if that allegation was made, and it ' s not documented, there was a risk for inaccurate documentation that could affect the monitoring that was provided to Resident #61. During an interview on 3/13/24 at 5:05 pm, the SW stated she did not remember what the verbal aggression details were and therefore it was not documented. The SW stated Resident #61 ' s clinical records were not documented at the time the meeting was held. Resident #30 Record review of Resident #30 ' s face sheet dated 03/14/2023 revealed she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #30 ' s History and Physical dated 02/21/2023 revealed she had diagnoses including COPD (chronic obstructive pulmonary disease - a condition where airways are narrowed, and breathing is difficult), chronic respiratory failure with hypoxia (a condition where airways are narrowed or damaged and there is reduced oxygen in the blood), and sleep disorder (changes in sleep that can negatively affect health.) Medications included a CPAP to be used nightly and 2 liters per minute of oxygen at night as needed. The History and Physical revealed that Resident #30 ' s family member said that facility staff was not placing her CPAP because the distilled water in the machine had not been used. The resident said she was not sleeping, although staff reported she was. Record review of Resident #30 ' s quarterly MDS dated [DATE] revealed she had a BIMS score of 9 (moderate cognitive impairment). She had no symptoms of delirium or psychosis. She had no behavioral symptoms including rejection of care during the 7-day look back period. She had diagnoses including COPD or chronic lung disease, and respiratory failure. The MDS indicated she was not receiving oxygen therapy. Record review of Resident #30 ' s Care plan dated 01/26/2023 revealed she refused to use her C-Pap Machine. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 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 #30 ' s physicians orders dated 11/15/2023 revealed she was to use a CPAP machine daily at bedtime. The physician's order dated 01/26/2024 revealed that her compliance with the use of the CPAP machine was to be documented in progress notes and the physician was to be notified if she was noncompliant. Record review of Resident #30 ' s progress note by LVN A dated 1/9/2024 revealed the resident was prompted throughout the night to keep her c-pap on with no success. The resident had intermittent labored breathing. Record review of Resident #30 ' s MAR for February 2024 revealed she was non-complaint with use of the CPAP machine on 02/14/2024 and 02/23/2024. Record review of Resident #30 ' s nursing progress notes February 2024 revealed no corresponding nursing notes regarding her refusal to use the CPAP machine as required by physician ' s order. Record review of Resident #30 ' s MAR for March 2024 (03/01/2024 - 03/12/2024) revealed she had no instances of non-compliance with use of the CPAP machine. Record review of Resident #30 ' s respiratory therapy report dated 03/14/2024 for 12/15/2023 - 03/13/2024 revealed she used the CPAP machine 33 out of 90 days and had not used the CPAP machine on 57 nights. During February 2024 she did not use the CPAP machine on 02/01, 02/02, 02/03, 02/04, 02/07, 02/09, 02/10, 02/14, 02/16, 02/17, 02/19, 02/22, 02/23, 02/24, 02/28, and 02/29/2024. Between 03/01/2024 and 03/13/2024 she did not use the CPAP machine the nights of 03/01, 03/02, 03/01, 03/08, 03/09, 03/11, 03/12, and 03/13/2024. In an interview on 03/11/24 at 11:19 AM with Resident #30 and her family member, the family member said that staff were not putting the CPAP on the resident at night. The resident stated that this was correct. The family member said a man came in to look at the machine and said they [nursing staff] do not put it on her. The resident said she had difficulty putting the CPAP mask by herself. In a telephone interview on 03/14/24 at 09:28 AM Respiratory Therapist C revealed that he was familiar with Resident #30 and that he could provide records regarding the frequency with which she used the CPAP machine. In an interview on 03/14/24 at 11:34 AM Respiratory Therapist C revealed that review of Resident #30 Therapy Report documented that in March 2024 the resident did not have the CPAP mask on at all, and that based on the electronic record from the CPAP machine, between 12/15 and 3/13 she did not use the CPAP machine 57 times. The Respiratory Therapist stated that not using the CPAP machine put Resident #30 at risk of poor sleep quality and increased instances of sleep apnea. In an interview on 03/14/24 at 02:10 PM the DON revealed that the nurses should be documenting if Resident #30 refused to use her CPAP machine. She stated that if the resident did not use the CPAP machine, she would be at increased risk of sleep apnea and might lose breathing at night. She said the nurses should be following physician ' s orders to document instances when Resident #30 refused to use the CPAP machine. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 03/14/24 at 02:28 PM ADON D revealed she thought Resident #30 was generally compliant with all orders including use of the CPAP machine. She stated that noncompliance with use of the CPAP machine could result in Resident #30 ' s feeling winded, short of breath, and might exacerbate her COPD. In an interview on 03/14/24 at 04:16 PM, LVN A revealed that during the time she worked with Resident #30, other staff told her the resident refused to use the CPAP machine. LVN A said on nights she worked with Resident# 30s she (the LVN) put the CPAP mask on Resident #30 herself because the resident was not able to put it on herself. The LVN said she had not had any difficulties with Resident #30 ' s use of the CPAP after educating the resident about the risks of not using the CPAP. The LVN said that if the resident did not want to put the machine on right away the LVN would go back and put it on her later in the evening. Record review of the facility policy Charting and Documentation revised 08/2006 revealed that all services provided to the resident, or any changes in the resident ' s medical or mental condition, shall be documented in the resident ' s medical record. All observations, medications administered, services performed and so forth must be documented in the resident ' s clinical records. All incidents, accidents or changes in the resident ' s condition must be recorded. Documentation shall include at a minimum whether the resident refused the procedure/treatment.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 20026 Based on interviews and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for 13 of 14 meetings reviewed for QAPI. The facility did not ensure the MD, or a representative and Infection Preventionist attended QAPI meetings. This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented, and no appropriate guidance developed. Findings included: Interview on 03/14/24 at 10:23 AM, the DON revealed the facility held monthly QAPI meetings. The DON stated all department heads, and the Medical Director attended the QAPI meetings. The DON stated the Medical Director had only attended one QAPI meeting in 2023 and none in 2024. Record review on 03/14/24 10:28 AM with the DON of QAPI Signature Sheets for 2023 revealed the following: 02/16/23 Medical Director and/or designee did not attend QAPI meeting. 03/15/23 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. 04/12/23 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. 05/11/23 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. 06/21/23 Medical Director and/or designee did not attend QAPI meeting. 07/13/23 Medical Director and/or designee did not attend QAPI meeting. 08/09/23 Medical Director and/or designee did not attend QAPI meeting. 09/06/23 Medical Director and/or designee did not attend QAPI meeting. 10/04/23 Medical Director and/or designee did not attend QAPI meeting. 11/05/23 Medical Director attended QAPI meeting. 12/13/23 Medical Director and/or designee did not attend QAPI meeting. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/12/24 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. 02/07/24 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. 03/06/24 Medical Director and/or designee did not attend QAPI meeting; Infection Preventionist did not attend QAPI meeting. In an interview on 03/14/24 at 10:33 AM, the DON reported that she had just hired a new IP, so she had been filling in as the IP. In an interview on 03/14/24 at 11:26 AM, the Administrator reported that they conducted monthly QAPI meetings. He stated that all department heads attended the QAPI meeting. He stated the Medical Director only attended Quarterly QAPI meetings. The Administrator confirmed that the Medical Director had only attended one QAPI in 2023 and none in 2024.

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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 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.

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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)

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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.

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F 0908

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Keep all essential equipment working safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20026

Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for one (Resident #37) of 21 residents reviewed for safe operating condition of patient care equipment and for 1 of 1 kitchen reviewed for safe operating equipment.

-The facility failed to ensure that the mechanical lift (Hoyer) sling used to transfer Resident #37 was in good working order, resulting in a sling strap tearing, and Resident #37 falling to the floor.

-The facility failed to keep the ice machine in safe operating condition.

This failure could result in residents fearing transfers using a mechanical lift, and serious injury, including fractures. This failure could place residents at risk of foodborne illnesses.

Findings included:

Record review of Resident #37 ' s face sheet dated 03/14/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE].

Record review of Resident #37 ' s quarterly MDS dated [DATE] revealed he had a BIMS score of 12 (moderate cognitive impairment). He was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and personal hygiene. He was dependent on staff for bed to chair/ chair to bed transfers and tub/shower transfers. He was always incontinent of bowel and bladder. His diagnoses included end-stage renal disease (kidney failure), heart failure, and morbid obesity.

Record review of Resident #37 ' s care plan dated 03/07/2024 revealed he was at risk for falls, and the maintenance department was to check all Hoyer lift nets and straps to make sure they were not torn or old and could be used safely. His care plan dated 06/20/2023 revealed he would receive assistance with ADLs.

Record review of Resident #37 ' s Resident Incident Report dated 03/14/2024 revealed that on 03/06/2024 he was being transferred from a shower chair in a Hoyer sling when the Hoyer strap broke. He was observed to be on the floor on his left side and said he had pain in his left leg. His physician was notified and x-ways of his left hip and leg were ordered.

Record review of Resident #37 ' s Nursing Progress Note dated 03/06/2024 revealed that at 2:45 PM a CNA (unidentified) called LVN I into his room, where the resident was observed laying on the floor on his left side. Per the CNAs (2) they were transferring the resident onto the bed after his shower when the Hoyer strap broke. The resident voiced pain to the left leg down to the ankle. The resident was able to move his left arm and denied any new pain except throbbing to his left leg.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 03/11/24 at 10:58 AM Resident #37 revealed that on the past Wednesday [03/06/2024] staff members were transferring him in a Hoyer lift when the sling broke and he fell to the ground landing on his left side. Resident #37 was observed to have a bruise on his left wrist. Resident #37 said an x-ray machine was brought om and the did [his] whole left side and found nothing. He said that he hit his left foot on the lift and that his side under his left breast hurt. In interviews with three CNAs (CNA J on 03/14/24 at 11:53 AM; CNA K on 03/14/24 11:28 AM, and the Lead CNA on 03/14/24 at12:09 PM) all confirmed that they had received prior training to check Hoyer slings to make sure they were in good condition. In an interview on 03/14/24 at 01:28 PM Laundry Worker M revealed she had been instructed and does inspect Hoyer nets for wear. She said that if there was a problem with the condition of the sling, she would tell the Maintenance/Housekeeping Manager. In an interview on 03/14/2024 at 2:55 PM the DON said that in response to Resident #37 ' s fall, staff had been in-serviced to make sure to hook the Hoyer sling to the mechanical lift using two loops instead of one in order to reduce the risk of a sling strap breaking and a resident falling to the ground. Ice Machine: Observation on 03/11/24 at 8:36 AM, with the Cook revealed the ice machine had white calcium build-up inside on right side of ice machine and rusted areas where hinged plastic door closed. It was observed that there was white calcium build up and rust around the bottom of the ice machine. The Cook reported that the ice machine was cleaned once a month. Observation and interview on 03/13/24 at 1:22 PM, with Dietary Manager demonstrated to the state surveyor that the ice machine had been leaking water from the ice maker that drips directly into the ice bin. She stated, This has been going on for approximately 6 months. That is what is causing the white calcium build-up and rust inside on the right side of the ice machine where the water is leaking, and calcium build up down the sides and bottom of the ice machine, and on the tile floor around the ice machine. The Administrator and the Maintenance Director are aware that the ice machine has been leaking water for 6 months and are pending an approval on a quote to replace the ice machine. It was observed that the vent on the ice machine had a copious amount of light gray lint. Interview on 03/13/24 at with Maintenance Director confirmed that ice machine had been leaking water for several months and that he cleaned the ice machine as needed to keep the water from leaking into the ice bin. He stated, We have several quotes for a new ice machine and are pending corporate approval. Record review of the facility policy Safe Lifting and Movement of Residents revised 4/2007 revealed that the facility would use mechanical lifting devices to protect the safety and well-being of residents. Mechanical lift equipment shall undergo routine checks and maintenance by nursing and maintenance staff to ensure that equipment remains in good working order.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43871 Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in four of four halls reviewed for condition of handrails. The facility failed to ensure that the handrails throughout the facility did not have the paint worn off them. This failure could put residents at risk of feeling a decreased sense of well-being, and at increased risk for splinters because of the poorly maintained condition of the handrails. Findings included: Handrails: Observation on 03/14/2024 at 2:30 PM of the handrails in the 100 and 200 halls revealed that the brown paint on all handrails was worn through and that the wood showed through the paint. Observation of the handrails at hall 300 on 3/13/2024 at 3:42 PM revealed that the brown paint on all handrails along the hallway was scraped and worn and wood showed through the paint. Observation of the handrails at hall 400 on 3/13/2024 at 3:46 PM revealed that the brown paint on all handrails along the hallway was scraped and worn and wood showed through the paint. Supply Storage Rooms in 100 and 200 Halls: Soiled Utility Room: Observation on 03/14/24 at 9:39 AM - 10:01 AM with ADON and Central Supply Clerk revealed: -Mop Basin had black substance around the sides and area around the drain. The plaster and paint were chipped, with multiple holes on walls and black marks where Mop Basin was located. The borders on the walls were full of dust. The floor in the soiled utility room had large areas covered with black marks, dried water stains, and dusty floor, piece of paper on the floor and small paper particles throughout the room. -The wall directly below locked cabinets revealed wall had large areas of plaster had fallen off and chipped paint on the wall directly where boxes of gloves were stored. Storage Room located in Hallway that connects the 100 and 200 Halls revealed: Observation on 03/14/24 at 10:05 AM with ADON, Maintenance Director and Central Supply Clerk revealed Ceiling Light was missing the light cover. There was a large brown water stain above ceiling light that extended to the area where supply boxes were stored on the floor. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/14/24 at 11:38 AM, the Maintenance Supervisor confirmed floors in storage rooms were dusty, had black stains, boxes were stored on the floor, mop basin had back stains around the inside and outside of the basin, storage racks were full of dust and dried white stains, clean supplies were stored with contaminated containers and/or next to vacuum cleaners in clean storage room, confirm light cover was missing in one storage room. He stated the brown water stain on ceiling in the storage room was caused by a water leak from air conditioner. He stated, Nursing had not reported the water leak to maintenance. Interview and record review with Administrator on 03/14/24 at 11:30 AM confirmed all the environmental findings observed in Storage Rooms where nursing supplies were kept. The administrator said he was not aware of any issues with the storage room walls, dried water stain on the ceiling, missing light cover and the dirty floors. 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.