

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 04/30/2025
NAME OF PROVIDER OR SUPPLIER Edgemere Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 2 of 22 residents (Resident #16 and #178).</p> <p>The facility failed to ensure resident call lights were within reach for 2 residents (Resident #16 and #178).</p> <p>This failure placed residents at risk of having their needs unmet when they are unable to contact staff.</p> <p>Findings included:</p> <p>Resident #16</p> <p>Record review of Resident #16's face sheet dated 04/30/2025 revealed Resident #16 was originally admitted to facility on 02/10/2016 and readmitted on [DATE].</p> <p>Record review of Resident #16's History and physical dated 05/08/24 revealed a [AGE] year-old female diagnosed with vascular dementia.</p> <p>Record review of Resident #16's Quarterly MDS dated [DATE] revealed Resident #16's BIMS score was 02 indicating severe cognitive impairment. Resident needed Extensive assistance with bed mobility, transfers and toileting (resident involved in activity; staff provide weight bearing support).</p> <p>Record review of Resident #16's care plan reviewed on 04/05/24 revealed she was at risk for falls, and interventions included to ensure call light is available to resident.</p> <p>An observation on 04/28/25 at 10:15 a.m., revealed Resident #16's call light was pinned between two pillows that she was laying on top of.</p> <p>Resident #178</p> <p>Record review of Resident #178's face sheet dated 04/30/2025 revealed a [AGE] year-old male that was admitted to facility on 04/03/2025.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #178's medical diagnosis list revealed, Resident #178 was diagnosed with cognitive communication deficit, and unspecified dementia.</p> <p>Record review of Resident #178's Quarterly MDS dated [DATE] revealed no BIMS score. Resident was dependent(helper does all the effort) for toileting , bed mobility and transfers</p> <p>Record review of Resident #178's care plan dated 04/05/2025 revealed he was at risk for falls related to confusion, gait/balance problems, incontinence, poor communication/ comprehension, unaware of safety needs. Interventions included to ensure call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>An observation on 4/28/25 at 10:05 a.m., revealed Resident #178's call light was on the floor next to the head of the bed, while he was sleeping in bed.</p> <p>In an interview on 04/30/2025 at 12:19 p.m., with the DON she said the call lights were for patients to be able to call for assistance. She stated call bells should be kept within residents' reach. She stated the CNA's, nurses and overall, all staff were responsible for ensuring residents call lights were within reach. She stated that if call lights were not kept within residents' reach, then residents could possibly not be able to call for help when needed. She stated that an Inservice for call lights was done recently.</p> <p>In an interview with LVN A on 04/30/2025 at 12:50 p.m.,she said that the call lights were supposed to be within reach of all residents. She stated that all staff were responsible for ensuring call lights were within reach of residents. She stated that residents were rounded every 2 hours and as needed. She stated that if the call lights were not within reach of the resident, residents could sustain a fall, or they would not be able to call for help. She stated that the facility was always providing in-services regarding call lights, and she stated that the most recent was at the beginning of April 2025.</p> <p>In an interview with CNA B on 4/30/25 at 1:00 p.m, she said that call lights were for residents to use to call for assistance and for staff to attend to them as soon as possible. She stated that call lights were to always be in reach of the resident. She stated that CNAs and nurses were responsible for ensuring call lights were always within reach for the residents. She stated that if call lights were not within reach, it could delay care and could result in a resident sustaining a fall. She stated that the facility was constantly conducting in-services on keeping call lights within reach and answering them in a timely manner, but she could not remember the most recent one.</p> <p>Review of facility policy dated September 2022 and titled Call System, Resident read in part Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's environment was as free of accident hazards as possible for 4 of 22 residents (#36, #53, #68 and #70) reviewed for accidents.</p> <p>-The facility failed to properly dispose of a retractable lancet device (small, pen like tool that holds a lancet (a small needle) used to prick the skin for blood sampling) in sharps container in one room (resident# 36 and resident#53's room)</p> <p>-The facility failed to properly dispose of blood-stained alcohol prep pads in two rooms (resident#36,#53,#68 and #70 rooms)</p> <p>This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents.</p> <p>The findings included:</p> <p>Resident #36</p> <p>Record review of Resident #36's face sheet dated 04/30/2025 revealed a [AGE] year-old female that was originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #36's History and Physical dated 04/02/25 revealed, Resident #36 was diagnosed with Alzheimer's disease, unspecified dementia with agitation.</p> <p>Record review of Resident #36's Quarterly MDS dated [DATE] revealed no BIMS score.</p> <p>Record review of Resident #36's care plan dated 04/10/25 revealed the Resident has an ADL self-care performance deficit related to Alzheimer's, and the resident had impaired cognitive function/ dementia or impaired thought processes related to Alzheimer's.</p> <p>Resident # 53</p> <p>Record review of Resident #53's face sheet dated 04/30/2025 revealed an [AGE] year-old female that was originally admitted to the facility on [DATE].</p> <p>Record review of Resident #53's history and physical dated 04/22/25 revealed, Resident #53 was diagnosed with</p> <p>Unspecified dementia.</p> <p>Record review of Resident #53's quarterly MDS dated [DATE] revealed a BIMS score of 05 indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/30/2025 at 12:50 pm with LVN A she said that all contents were to be disposed of completely in the sharp's container. She stated that it was the responsibility of whoever was disposing of the items to make sure that they were placed all the way inside the container. She stated that if items were left in the reach of residents, they could be at risk for needle sticks and ingestion.</p> <p>In an interview on 04/30/2025 at 1:30 pm with administrator he said that sharps containers are used to dispose of hazardous items. He stated that contents are supposed to be disposed of completely inside the container. He stated that if items were left in the reach of residents, residents could get injured.</p> <p>Review of facility policy revised January 2012 and titled Sharps Disposal read in part The facility shall discard contaminated sharps into designated containers. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51012</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, for 1 of 3 nurse carts checked for medication storage.</p> <p>The facility failed to ensure liquid medication stored in the medication cart in one hall (300 hall) did not have dried drippings on the sides of the bottles.</p> <p>This failure could affect residents that received medications at the facility by placing them at risk of not having prescribed medications and cross contamination.</p> <p>The findings include:</p> <p>In an observation on 04/29/2025 at 10:49 AM, dried drippings were revealed on a Lactulose Solution liquid bottle and a ProHeal Liquid Protein bottle in the medication cart for 300 halls. LVN E stated the bottles were to be clean and no dried drippings were to be on medications. She stated nurses and medication aides were responsible for maintaining the medication cart and everything it contained, clean and organized.</p> <p>In an observation on 04/29/2025 at 10:49 AM, dried drippings were revealed on a Lactulose Solution liquid bottle and a ProHeal Liquid Protein bottle in the medication cart for 300 halls. LVN E stated the bottles were to be clean and no dried drippings were to be on medications. She stated nurses and medication aides were responsible for maintaining the medication cart and everything it contained, clean and organized.</p> <p>In an interview on 04/30/2025 at 12:15 PM with the DON she said that medication aides and nurses were responsible for maintaining cleanliness of the medication carts. She stated that staff were to clean their medication carts on a daily basis which included making sure medication bottles are free from dried drippings. The DON stated she and the ADON monitor medication carts once a week to make sure medications are clean. She stated the liquid medication bottles were to be clean after each use or when observed dirty. The DON stated the risks of medications having dried drippings on the bottle was a cross-contamination concern that can affect the residents. She stated a possible risk included residents can become ill.</p> <p>In an interview on 04/30/2025 at 12:34 PM with LVN A she said nurses were responsible for keeping medications in the medication carts clean. She stated nurses were to monitor their medication cart and medications it contained, clean once a shift and throughout their shift. She stated the DON monitors medication carts daily for compliance. She stated the risks of medications having dried drippings on the bottle included infection control concerns since it is unknown what the dried drippings residue contained. She stated this can place residents at risk for illness.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/30/2025 at 2:03 PM with the ADON she said nurses and medication aides were responsible for the medication bottles' cleanliness. The ADON stated the afternoon and night shift nurses were given the task to review medication carts for cleanliness including medication bottles, since there were less medications to administer at those times. She stated the DON, and the Weekend Nurse Supervisor monitor medication carts and ensure medications were being cleaned properly on a weekly basis. The ADON stated the risk for the residents being administered medications with dried drippings is a possible infection control concern.</p> <p>Record review of facility's policy, Storage of Medications, dated with revision date April 2007, read in part: The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy did not specify about medication bottle maintenance.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49854</p> <p>Based on observations, interviews, and record review 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.</p> <p>The facility failed to store frozen vegetables, frozen cookie dough and sausage patties, in a closed box and sealed bag inside the freezer to prevent food contamination and freezer burn.</p> <p>The facility failed to keep a 1-gallon bottle of Worcestershire's sauce free of dry drippings and residues on the bottle.</p> <p>The facility failed to keep the ice machine and its filters clean and free of dust and lint.</p> <p>The facility failed to keep the deep fryer free of food particles, grease accumulation, and burnt oil, and the stove wall next to the fryer was not free of oil splatter and food particles.</p> <p>These failures could place residents at risk of food borne illnesses.</p> <p>Findings included:</p> <p>In an Observation of freezer #2 and Interview on 04/28/25 at 08:10 AM with the Nutrition Supervisor there was a box of mixed vegetables, oriental blend to the left side of the freezer and a box of chocolate chip frozen cookie dough to the right of the freezer. Neither box was closed and the bags containing the food were not sealed or tied with a knot. The Nutrition Supervisor stated that the bag containing the vegetables, and the cookie dough should not be unsealed and that it was expected for staff to tie close the bag to avoid the contents being exposed and contaminated, or for them to get freeze burn. She stated the potential outcome of the vegetables and cookie dough not being properly closed could expose them to cross contamination and potentially making the residents sick.</p> <p>In an Observation of refrigerator #3 and Interview on 04/28/25 at 08:16 AM with the Nutrition Supervisor there was an open box with an open bag containing sausage patties. The Nutrition Supervisor stated the bag should be sealed and the box should be closed. She said this could result in the patties being contaminated or getting spoiled and the potential outcome could be the residents getting sick if they consumed the contaminated patties.</p> <p>In an Observation and Interview on 04/28/25 at 08:21 AM with the Nutrition Supervisor in the dry storage room, on the first metal rack to the left of the entrance of the pantry a 1-gallon bottle of Worcestershire's sauce had dry drippings on the side. The Nutrition Supervisor stated this could attract insects, potentially contaminating other food in the pantry or kitchen. If insects contaminated ingredients, residents could get sick from consuming food prepared with those ingredients.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an Observation and Interview on 04/28/25 at 08:26 AM with the Nutrition Supervisor, the ice machine had dust and lint on its filters and top. The Nutrition Supervisor stated that the ice machine was expected to be clean and free of dust and lint. The potential problems were that the ice could get contaminated, making residents sick if they used it in their drinks, or the machine could malfunction and stop working due to dirty filters.</p> <p>In an Observation and Interview on 04/28/25 at 08:30 AM with the Nutrition Supervisor, the deep fryer was full of oil that looked burnt and black. Grease had built up on the top and sides, and food particles were on the outside of the fryer. The stove wall to the right of the fryer had oil splatter and food particles on it. The Nutrition Supervisor stated that the deep fryer and the stove looked dirty with oil and grease and that staff were expected to clean them after cooking and leaving the appliances dirty was not acceptable because it could lead to cross-contamination to the resident's food and potentially make them sick.</p> <p>In an interview on 04/30/25 at 10:02 AM with Nutrition Aide C, she said everyone in the kitchen oversaw cleaning their stations. Nutrition Aide C said she believed that maintenance oversaw cleaning of the ice machine She stated it was the cook's responsibility to clean the deep fryer and the stove, and she did not know if only the cook was responsible for cleaning these items. She stated that it was important for the kitchen utensils and equipment to be clean to avoid the residents getting sick. She also stated that food inside the fridges needed to be stored in sealed and labeled containers to avoid contamination and residents getting sick. Nutrition Aide C said that food and vegetables left uncovered and not sealed in the fridge was not acceptable because there was a risk of contamination that could potentially get the resident's sick. Nutrition Aide C stated the kitchen equipment was dirty and was not acceptable and could also get the residents sick by contaminating their food if it came in contact with the appliances' dirty surface.</p> <p>In an interview on 04/30/25 at 10:15 AM with Nutrition Aide D, she stated that food and vegetables needed to be inside a bag dated and sealed to avoid microbes getting into the food or odors from the fridge, and also to prevent spoilage. Nutrition Aide D said the risk of leaving food inside a bag unsealed or tied with just a knot was that the food could get contaminated or spoiled. She added that a resident could get sick or intoxicated if they were served food that got contaminated from being left open in the fridge. Regarding the dirty equipment such as the deep fryer, stove, and ice machine, Nutrition Aide D stated it was the responsibility of all staff members to ensure it was clean and sanitized because the potential outcome could be residents getting sick from contaminated food if the equipment was dirty. She stated that each staff member was in charge of cleaning their station once they were done working on it.</p> <p>In an interview on 04/30/25 at 10:28 AM with the Cook, she stated that vegetables and food such as the sausage patties needed to be stored in a container with a lid creating a seal. The [NAME] said If the vegetables were left in an opened bag, there was a risk of freezer burn or cross-contamination, and they had to be sealed either in a zip lock bag or by tying a knot on the bag after use. Regarding the dry drippings, The [NAME] stated they could potentially attract insects and potentially get the residents sick. She stated that the ice machine, the deep fryer, and stove were dirty and could potentially get the residents sick due to cross-contamination and bacteria.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/30/25 at 11:48 AM with the DON, she stated that the vegetables, cookie dough, and patties needed to be sealed inside of the fridge for infection prevention and control and there was a potential for residents to get sick if they got served a meal with contaminated or spoiled food. The DON said there was an expectation that the equipment in the kitchen be clean. Regarding the kitchen and the dirty ice machine, fryer, and stove, The DON explained there was a potential outcome of contaminating the food for the residents getting them sick from cooking and using dirty equipment.</p> <p>In an interview on 04/30/25 at 12:16 PM with the Administrator, he stated the bags in the fridge containing vegetables needed to be stored inside the bags and the bags needed to be properly sealed because if not, the food could get spoiled. For cleaning the kitchen, The Administrator said it was the expectation that the equipment was clean and without grease or crumbs.</p> <p>Record Review of the facility's policy dated revised on 3/2019, titled Food Storage, read in part: Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. All foods should be covered, labeled and dated.</p> <p>Record Review of the facility's policy dated 11/03/24, titled General Sanitation of Kitchen, read in part: The staff shall maintain the sanitation of the kitchen through compliance with written, comprehensive cleaning schedule. Tasks will be assigned to be the responsibility of specific positions.</p> <p>Record Review of the facility's policy dated 9/15/06, titled Cleaning Ice Machine, Scoop and Tray, read in part: The ice machine and equipment (scoops and trays) will be cleaned on a regular basis to maintain a clean, sanitary condition. Clean exterior of machine with detergent solution, Rinse and allow to dry.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public in 3 of 15 rooms from hallway 400.</p> <p>The facility failed to clean food and stains from the floor that looked like smeared fruit.</p> <p>The facility failed to clean the carpets of trash, debris, and food crumbs.</p> <p>The facility failed to clean an alcohol pad with dried blood from the floor.</p> <p>These failures placed residents and staff at risk of living, working, and visiting in an unsafe, unsanitary, and uncomfortable environment.</p> <p>The findings include:</p> <p>Resident# 5</p> <p>Record review of Resident# 5's admission record dated 4/28/2025 revealed a [AGE] year-old female with an admitted [DATE].</p> <p>Record review of Resident# 5's history and physical dated 1/7/25 revealed she had diagnoses of pulmonary disease, heart failure, type 2 diabetes, unspecified dementia, and major depressive disorder.</p> <p>Record review of Resident# 5's MDS assessment dated [DATE] revealed a BIMS of score of 12 indicating she had moderate cognitive impairment. The resident's functional abilities revealed she needed moderate assistance with oral and toileting hygiene, shower, lower body dressing and putting on or taking off footwear.</p> <p>Record review of Resident# 5's care plan revised on 4/22/25, revealed the resident wished to remain in the facility long term and resident and family members were encouraged to provide a home like environment. It indicated the resident had a communication problem and the facility was to anticipate and meet her needs. The care plan revealed Resident# 5 was at fall risk related to being unaware of safety needs.</p> <p>Resident# 46</p> <p>Record review of Resident# 46's admission record dated 4/28/2025 revealed a [AGE] year-old male with an admitted [DATE].</p> <p>Record review of Resident# 46's history and physical dated 3/14/25 revealed he had diagnoses of kidney failure, end of stage renal disease, abnormalities of gait and mobility, dementia, anxiety and depression unspecified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Edgemere Estates		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.			
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident# 46's MDS assessment dated [DATE] revealed a BIMS score of 13 indicating he was cognitively intact. It revealed he was impaired on one side to his upper extremities, and he needed moderate assistance with toileting and personal hygiene with substantial assistance for showers, lower body dressing and putting on or taking off footwear.</p> <p>Record review of Resident# 46's care plan revised on 3/14/25, revealed the resident expressed desire in activity involvement and encouraged visits from family, friends and clergy. It asked for staff to provide room visits two to three times per week to establish friendship and trust.</p> <p>Resident# 69</p> <p>Record review of Resident# 69's admission record dated 4/28/2025 revealed a [AGE] year-old male with an admitted [DATE].</p> <p>Record review of Resident# 69's history and physical dated 3/18/25 revealed he had diagnoses of Parkinson's disease, infection of the skin, cognitive communication deficit, muscle weakness, abnormalities of gait and mobility, unspecified intestinal obstruction and acute kidney failure.</p> <p>Record review of Resident# 69's MDS dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. It revealed he needed moderate assistance with oral hygiene and eating, and substantial assistance with toileting, shower, upper and lower body dressing and with putting on or taking off footwear.</p> <p>Record review of Resident# 69's care plan revised on 4/1/25, revealed the resident expressed some desire in activity involvement and encouraged visits from family, friends and clergy. It asked for staff to provide room visits two to three times per week to establish friendship and trust.</p> <p>In an observation on 04/28/25 at 10:01 AM in Resident # 69's room, the carpet had stains and pieces of paper and trash. Side B of the room also had stains on the carpet and food particles that looked like pieces of chips on the floor.</p> <p>In an observation on 04/28/25 at 10:20 AM in Resident # 5, the floor was dirty and had stains that appeared to be fruit, which looked stepped on and smeared. The stains were yellow and green and looked dry, as if they had been there for a significant amount of time. During a second observation at 1:53 PM, the floor continued to be dirty with the same stains.</p> <p>In an observation and interview on 04/29/25 at 10:24 AM, Resident # 46 and 69's rooms had trash, pieces of paper, and food crumbs. Resident #46 said his carpet was stained and that he had told the facility multiple times, but they had not cleaned it. Resident #69 stated that staff went to his room from time to time to take out the trash, but it took the staff a long time to clean his floor and carpet, which he said was cleaned once a day in the mornings.</p> <p>In an Observation and interview on 04/29/25 at 10:34 AM in Resident# 5's room, she was sitting on her wheelchair. She said that sometimes the floors were dirty, and staff took a long time to clean them. Observations revealed there was an alcohol pad on the floor with dry blood on it. Resident #5 stated she did not know if the alcohol pad belonged to her or her roommate.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Edgemere Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 10880 Edgemere Blvd El Paso, TX 79935	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/30/25 at 08:53 AM with the Housekeeper, she stated it was important to keep the residents' rooms clean because it was their house and they worked for them. She said it was the responsibility of all staff members to clean or report when a room was dirty, for housekeeping to assist the residents with cleaning. The Housekeeper stated that having food debris on the carpet was not acceptable because it could attract pests or insects which could contaminate surfaces in the room and could make the residents sick. She said that it could also make residents and family members feel as if the facility did a poor job maintaining the rooms clean and sanitized.</p> <p>In an interview on 04/30/25 at 11:00 AM with the Housekeeping Supervisor, he stated that it was not acceptable to have trash, debris, or food residues on the floors or carpets of the residents' rooms. He said there was a risk of attracting insects such as roaches or ants, which could potentially make the residents and visitors uncomfortable and make them feel like the facility did not pay attention to hygiene. Regarding the stains on the floor of Resident # 5, the Housekeeping Supervisor stated they could be food residue, sputum, or another bodily fluid, and the alcohol swab with blood residue posed an infection control hazard and there was a risk of cross-contamination for the residents.</p> <p>In an interview on 04/30/25 at 11:57 AM with the DON, she stated the expectation was for the residents' rooms to be cleaned daily and as needed. The DON said there was a potential to attract insects such as roaches and ants by leaving food crumbs on the floors or carpets. The DON said the stains on the floor of Resident # 5 looked like food, and there was a potential fall hazard if a resident stepped and slipped on it, resulting in a fall or accident. The DON stated the alcohol swab with blood residues posed a hazard for infection control if the resident had a health condition in their blood.</p> <p>In an interview on 04/30/25 at 12:45 PM with LVN A, she explained that the expectation was that housekeeping cleaned the rooms, floors, and carpets of the residents' rooms on a daily basis or as needed. LVN A said the floors for Resident # 69 Resident # 5 looked dirty and unclean. LVN A said the potential outcome could be that residents with dementia could ingest trash or food crumbs found on the floors or carpet, and there was the potential for them choking or getting sick from eating something found on the floor. LVN A stated if the stains on the floor of Resident # 5 were mucus or spit, and the alcohol pad with dried blood was from a resident with a blood infection or disease, it could result in cross-contamination or infection.</p> <p>In an interview on 04/30/25 at 01:07 PM with CNA B, she stated that the carpet and floors looked dirty with trash and crumbs. CNA B said there was a risk of cross contamination and that the food residues could attract insects and potentially get the residents sick. She stated that it was all staff's responsibility to make sure the rooms were clean and if a CNA was to find a room in that state, it was expected for them to clean it or to contact maintenance to assist with cleaning. CNA B said the stains on the floor and the alcohol pad with blood found on Resident # 5 could result in contamination and making residents sick.</p> <p>Record Review of the facility's policy with a revision date of 02/21 titled Homelike Environment, stated in part: The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, these characteristics include clean, sanitary and orderly environment.</p>		