

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, 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 disease and infection for 4 of 7 residents (Resident #96, Resident #43, Resident #66, Resident #82) reviewed for infection control. The facility failed to ensure the urinary catheter bags for Resident #96, Resident #43, Resident #66, and Resident #82 was anchored and secured to prevent infection. This failure could place residents at risk of infection due to improper care practices. Resident #96 Record review of Resident #96's face sheet dated 06/03/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #96's diagnoses included Pneumonia, (inflammation and fluid buildup in the lungs) Parkinsons Disease (brain disorder that affects movement in the body), Kidney failure (Kidneys have stopped working), Gastrostomy (an opening in the stomach to place a feeding tube), altered mental status (sudden change in how the brain works), metabolic encephalopathy (the brain has trouble working due to a chemical or metabolic problem). Record review of Resident #96's MDS dated [DATE], reflected a BIMS score of 09, which indicated moderate cognitive impairment. Resident #96 had an indwelling catheter. Record review of Resident #96's Order Summary Report dated 06/03/2026, revealed Foley Catheter Care everyshift Foley catheter care every shift with soap and water or may use wipes as appropriate/ desired by patient. Record review of Resident #96's Care Plan dated 06/03/2026, revealed focus [Resident #96] has a focus point The resident has Catheter: Neurogenic bladder(A Person loses control of their bladder because of nerve damage), Benign Prostatic Hyperplasia (Prostate Gland becomes enlarged) with a goal The resident will be/remain free from catheter-related trauma through review date. Interventions CATHETER: The resident has catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Check tubing for kinks each shift. INDWELLING CATHETER: Change catheter Q monthly and prn. 16fr/30cc. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation and interview on 06/02/2026 at 02:44 PM, Resident #96 was observed lying in bed, asleep. Resident #96 was unable to verbalize or communicate. Member S was present at the bedside. She stated she did not routinely check whether the catheter bag was touching the floor and was unaware of standards of practice related to catheter bag placement. Observation revealed Resident #96's catheter drainage bag was touching the floor. The drainage bag was positioned below the bladder however, it was not secured with the designated clips to prevent contact with the floor. Resident #43 Record review of Resident #43's face sheet (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident 82's diagnoses included sequelae of cerebral infarction (problems or side effects that remain from a stroke), type 2 diabetes mellitus with hyperglycemia (body could not use or make enough insulin), vascular dementia (Brain damage caused by poor blood circulation), Behavioral Disturbance (behavioral issue/difficulties), Dysphagia (difficult swallowing), Neuromuscular Dysfunction of Bladder (muscles that hold or release urine have nerve damage), cardiac arrhythmia (irregular heartbeat), Hyperlipidemia (High Cholesterol), Hypertension (high blood pressure). Record review of Resident #82's MDS dated [DATE], did not reflect a BIMS score, study was not conducted and skipped due to resident is rarely/never understood. Record review of Resident #82's Order Summary Report dated 06/03/2026, stated Indwelling Catheter Care every shift Indwelling catheter care every shift with soap and water or may use wipes as appropriate/ desired by patient, Urinary Catheter Care: Check for patency, Empty foley bag every shift Ensure that Privacy Bag is on at all Times to maintain Privacy, Foley Catheter: 16F 10cc bulb as needed for Occlusion or Leakage, Foley Catheter: Change Catheter Anchor as needed as needed. Record review of Resident #82's Care Plan dated 06/03/2026, revealed focus The resident has indwelling Catheter: Neurogenic bladder, Skin Breakdown with a goal The resident will show no s/sx of Urinary infection through review date and interventions CATHETER: Change catheter q month as needed. 16fr/10cc, CATHETER: The resident has catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door, Check tubing for kinks each shift., Monitor for s/sx of discomfort on urination and frequency, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, ever, chills, altered mental status, change in behavior, change in eating patterns. Observation of Resident #82 on 06/02/2026 at 10:01 AM, revealed Resident #82 was seen asleep in bed, and the resident's catheter bag was seen hanging from the bed rail below the bladder in a privacy bag. The privacy bag was lying on the floor. The catheter was not hung with the designated clips making the drainage bag hang low and come in contact with the floor. Observation on 06/02/2026 at 11:11 AM, revealed Resident #82 catheter bag was seen hanging from the bed rail below the bladder in a privacy bag. The privacy bag was lying on the floor. The catheter was not hung with the designated clips making the bag hang low and come in contact with the floor. In an interview on 06/02/2026 at 11:12AM, CNA R stated that she had been employed with the facility for about a year now and stated training are provided for foley/catheter care by the facility. CNA R stated during training staff were instructed to ensure the catheter bags were hung by the designated clips and placed below the bladder on the bed rails and to ensure the catheter bag do not touch the floor. CNA R observed Resident #82's catheter bag and stated that the main catheter bag should not be touching the floor and did not believe there was any risk because the catheter bag was placed in a privacy bag and the privacy bag was the one touching the floor. CNA R stated that was what she recalled from training but would go grab a new privacy bag and replace it since it was touching the floor. Observation and interview on 06/03/2026 at 09:00 AM, Med Aide P, stated she had been employed at the facility for almost a year now, and reported that all med aides, CNAs and RNs are responsible for ensuring Foley catheter bags were not placed on the floor. Med Aide P explained and demonstrated the process and procedures while attending to a resident with a Foley catheter. Med aide P knocked on the door to Resident #82, sanitized her hands and donned gloves. She then explained the process to Resident #82 and advised that she was just observing the location of the catheter bag. Med Aide P lifted the covers and observed the privacy bag was touching the floor. She stated that the privacy bag should remain below the bladder to allow urine to drain properly and that the designated clips should be secured to the bed (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 of 8 residents (Resident #64) reviewed for ADL care. The facility failed to ensure Resident #64's nails were trimmed and filed on 06/01/2026. This failure could place residents at risk of loss of dignity, risk for infections, and a decreased quality of life. Findings included: Record review of Resident # 64's admission record dated 06/03/2026 revealed an [AGE] year-old female with an original admission date on 3/24/2020 and a readmission date on 03/01/2024. Record review of Resident # 64's Physician's progress note dated 05/13/2026 revealed a diagnosis of Alzheimer's disease (a progressive neurological disorder that gradually destroys memory, thinking skills, and the ability to carry out simple daily tasks), and dementia (a loss of memory, language, and thinking abilities that are severe enough to interfere with daily life). Record review of Resident #64's Quarterly MDS dated [DATE] revealed no BIMS score. Section GG- Functional abilities revealed Resident #64 was dependent meaning helper did all of the effort. The resident did none of the effort to complete the activity; or the assistance of 2 or more helpers was required for the resident to complete the activity. Record review of Resident #64's care plan revised on 04/07/2026 revealed Resident #64 had an ADL self-care performance deficit related to Alzheimer's, impaired balance. Interventions included a one person assist with personal hygiene and oral care. An observation on 06/01/2026 at 11:39 AM revealed Resident #64's fingernails on both hands to be about 1.5cm from the nail bed. The resident was nonverbal; she could not answer questions. In interview on 06/03/2026 at 10:52 AM with CNA B, she stated that nails care was done every Sunday and as needed. She stated the importance for maintaining nail hygiene was to make sure there was no bacteria under the nails and to ensure nails were not too long where residents could scratch themselves or hurt themselves. She stated that it was the responsibility of the CNAs's and nurses to ensure that nails were kept trimmed and clean. In an interview on 06/03/2026 at 11:16 AM with LVN C, she stated nail care was performed on Sundays. She stated that nurses were responsible for ensuring CNAs were cutting the residents' nails. She stated the risk of residents having long nails was potential injuries to skin because they could scratch themselves. In an interview on 06/03/2026 at 11:47 AM with the DON, she stated nail care was done weekly and as needed. She stated that nurses and CNAs were responsible for ensuring nails were trimmed and clean. She stated that residents with long nails were at risk of injury such as skin breakage. In an interview on 06/03/2026 at 2:13PM with the Administrator, he stated that nail care was provided and monitored on an as needed basis. He stated that the beautician, CNAs, nurses, and activities director could all provide nail care to residents. He stated it was all the staff's responsibility to ensure residents' nails were trimmed and clean. He stated that a risk to the residents would be injury resulting from scratching. Review of facility policy titled Care of Fingernails/Toenails revised October 2010 read in part . The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed.		

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to ensure the resident's environment was as free from accident hazards as possible for 3 of 12 residents (Resident#32, #51 and Resident # 84) reviewed for accidents. 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 #32), a syringe in one room(Resident#51 and Resident #84) ,and blood-stained alcohol prep pads in two rooms (Resident #32, #51 and Resident #84). This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents. Findings included: Record review of Resident # 32's admission record dated 06/03/2026 revealed a [AGE] year old female with an original admission date on 01/25/2021 and a readmission date of 05/06/2024. Record review of Resident # 32's diagnosis list dated 06/03/2026 revealed a diagnosis of vascular dementia (a decline in thinking and memory skills caused by reduced blood flow to the brain, which deprives brain cells of vital oxygen and nutrients). Record review of Resident #32's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 04 indicating severe cognitive impairment. Record review of Resident # 32's care plan revised 05/07/2026 revealed Resident # 32 had impaired cognitive function or impaired though process related to dementia. An observation of Resident #32's room on 06/03/2026 at 1:27PM revealed a blood stained alcohol prep pad, 2 lancets and a syringe in the slot of the sharp's container located on the wall of the bathroom. Record review of Resident # 51's admission record dated 06/03/2026 revealed an [AGE] year old female with an admission date on 05/04/2026. Record review of Resident # 51's History and Physical dated 05/04/2026 revealed a diagnosis of advanced Alzheimer's dementia (a progressive brain disorder and the most common type of dementia). Record review of Resident # 51's MDS assessment dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident # 51's care plan revised on 06/02/2026 revealed Resident #51 had impaired cognitive function/impaired through process related to diagnosis of dementia, BIMS score of 03. Record review of Resident # 84's admission record dated 06/03/2026 revealed an [AGE] year-old female with an admission date on 11/11/2022. Record review of Resident # 84's physician's progress note dated 05/20/2026 revealed a diagnosis of unspecified dementia (cognitive decline or memory loss without exact underlying cause). Record review of Resident # 84's quarterly MDS dated [DATE] revealed a BIMS score of 05 indicating severe cognitive impairment. Record review of Resident # 84's care plan revised 05/28/2026 revealed Resident #84 had had impaired cognitive function/impaired through process related to diagnosis of dementia. An observation of Resident #51's and 84's room on 06/01/2026 at 11:27AM revealed a blood stained alcohol prep pad, and 3 lancets in the slot of the sharp's container located on the wall of the bathroom. In an interview on 06/03/2026 at 10:25 am with LVN A revealed 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 it was 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 injury. In an interview on 06/03/2026 at 11:47 AM with the DON revealed that the purpose of the sharp's containers were to dispose of any biohazard/ sharp items. She stated contents were to be disposed of in the sharp's container were to be disposed of all the way inside the container. She stated that all staff were responsible for ensuring that there were no contents left sitting in the drop slot of the sharp container. She stated that when contents were left in the reach of residents, this (continued on next page)		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpsters reviewed for garbage disposal. -The facility failed to ensure the dumpster was closed on 06/01/2026. -The facility failed to ensure refuse, including construction debris and organic food waste, was disposed of inside the dumpster and not left exposed in a trash cart on 06/01/2026. These failures could place residents, staff, and visitors at risk of infestation of rodents and insects. Findings included: During the initial kitchen tour, an observation and interview were conducted on 06/01/2026 at 11:16 a.m. with the Nutrition Supervisor at the rear of the facility. The dumpster was observed open on one side with multiple trash bags visible, including bags containing adult briefs. A strong foul odor was present throughout the dumpster area. Adjacent to the dumpster, a trash cart containing construction debris, discarded fast-food bags, and other organic refuse was observed uncovered and exposed to the environment. The Nutrition Supervisor stated it was not appropriate for the dumpster to remain open or for construction debris and organic waste to be left uncovered outside of the dumpster. She stated these conditions had the potential to attract insects, flies, cockroaches, rodents, stray animals, and other pests, which could gain access to the exposed refuse, scatter trash throughout the area, create unsanitary conditions, and contribute to foul odors around the facility. During an interview on 06/03/2026 at 10:04 a.m. Housekeeper D stated that staff were expected to ensure dumpster lids remained closed when dumpsters were not actively being used. Housekeeper D stated that open dumpsters could attract insects, rodents, and other pests to the facility grounds. Housekeeper D stated that exposed refuse could create unpleasant odors and negatively affect the cleanliness and appearance of the facility. Housekeeper D stated that maintaining dumpsters in a closed position helped promote a sanitary environment for residents, visitors, and staff. During an interview on 06/03/2026 at 10:11 a.m. Housekeeper E stated that dumpsters should remain closed after trash was disposed of. Housekeeper E stated that open dumpsters increased the risk of pest activity and could contribute to unsanitary conditions around the building. Housekeeper E stated that exposed trash could create offensive odors and detract from the overall cleanliness of the facility. Housekeeper E stated that all staff shared responsibility for maintaining a clean and safe environment. During an interview on 06/03/2026 at 11:31 a.m. the DON stated that dumpsters were expected to remain closed except during active use. The DON stated that open dumpsters could attract vermin, insects, and other pests which could present sanitation concerns. The DON stated that improperly secured dumpsters could create foul odors and environmental hazards that could impact residents and visitors. The DON stated that staff were expected to identify and report environmental concerns to the maintenance director of the Administrator for prompt correction. During an interview on 06/03/2026 at 11:37 a.m. the Maintenance Supervisor stated that part of his responsibilities included monitoring the exterior grounds and ensuring dumpsters remained in good condition and properly closed. He stated that leaving dumpsters open increased the likelihood of attracting pests and wildlife. He stated that open dumpsters could create odor concerns and negatively affect the facility's sanitary conditions. He stated that maintaining closed dumpsters was necessary to provide a clean, safe, and well-maintained environment. During an interview on 06/03/2026 at 1:30 p.m. LVN C stated that dumpsters should remain closed when not actively receiving trash. LVN C stated that open dumpsters could result in pest infestations, unpleasant odors, and sanitation concerns. LVN C stated that environmental hazards had the potential to affect resident health and quality of life. LVN C stated that staff were responsible for reporting observed concerns to management to ensure corrective action was taken. (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 06/03/2026
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)		
F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 06/03/2026 at 3:12 p.m. the Administrator stated that he did not identify any potential negative outcomes associated with the dumpster being left open. He stated that he had not observed issues related to pests, odors, or sanitation concerns resulting from the open dumpster. He stated, however, that the facility's policy required dumpsters to remain closed when not actively in use. He acknowledged that staff were expected to follow the facility's policy regarding dumpster management and environmental services practices. Record review of the facility's policy titled Food-Related Garbage and Refuse Disposal revised in October 2017, revealed in part. Policy Statement Food-related garbage and refuse are disposed of in accordance with current state laws. Policy Interpretation and Implementation 1. All food waste shall be kept in containers. 2. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. 6. Storage areas will be kept clean at all times, and shall not constitute a nuisance. 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.		