STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676283	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Arcos Del Norte Care Center	11169 Sean Haggerty El Paso, TX 79934

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on interviews and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 2 (Resident #3 and Resident #5) of 4 residents reviewed for neurological checks. -The facility failed to ensure Resident #3 had neurological checks done after a fall on 02/25/24. -The facility failed to ensure Resident #5 had neurological checks done after a fall on 03/13/24. This failure could affect others by placing them at risk of changes in condition due to not conducting neurological checks. Findings included: Resident #3 Record review of Resident #3's face sheet dated 04/02/24, revealed admission on 12/02/21 and re-admission on 03/26/24 to the facility. Record review of Resident #3's clinic history and physical dated 01/22/24, revealed, a [AGE] year-old male diagnosed with Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) and anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #3's Nursing Home discharge MDS assessment dated [DATE], revealed, there was no BIMS score as the cognitive assessment was not taken. Resident #3's activities of daily living revealed substantial/maximal assistance for hygiene, toileting, shower, and dressing. Resident #3 also needs substantial/maximal assistance with toilet transfers, sit to stand, sit to lying, chair to bed and bed to chair transfers, and shower transfers. Resident #3 was diagnosed with muscle weakness, lack of coordination, dementia, and epilepsy (a neurological condition involving the brain that makes people more susceptible to having recurrent unprovoked seizures). Resident #3 has had one fall since admissions with no injury. Record review of Resident #3's care plan dated 03/02/24, revealed, at risk for falls due to abnormal gait and mobility. Care plan dated 01/27/24, revealed, at risk for falling due to lack of coordination. Care plan dated 01/08/24, revealed, at risk for injury due to history of falls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's progress notes by RN H dated 02/25/24 at 9:38 AM, revealed, Resident #3 sustained a fall upon shift change. Resident #3 was noted to be on fall mat upon assessment. Head to toe assessment done, no injuries noted, no complaint of pain. No sign or symptoms of distress. Care plan updated. Resident #3 will remain free of falls and injuries associated with falls. Call bell within reach, bed to lowest position. Education provided. MD , DON, POA notified. Will continue to monitor. Record review of Resident #3's Fall incident/accident investigation worksheet dated 02/24/24, revealed, to be found on the floor at 6:15 AM. No apparent injury noted. Resident #3 was stable and not in distress. Resident #3 was asked if he had a reason to get up from bed and replied why he did not know. Behavior/Cognition - unknown (unwitnessed fall). Investigation worksheet did not provide any neurological checks as per facility protocol/policy for unwitnessed falls or (suspected) head injury. During an interview on 04/03/24 at 2:24 PM, with the DON, she stated neurological checks were to be taken when a resident was witnessed to have hit their head, had an unwitnessed fall, or a suspected/seen head injury. The DON stated if the resident does hit their head or suspected, the physician gets notified and the resident gets sent out to the hospital. The DON stated the negative outcome of not doing neurological checks could be missing an injury to the head. The DON stated it was expected for the nursing staff to be conducting neurological checks for unwitnessed falls, witnessed falls with head injury, and injuries to the head. During an interview on 04/04/24 at 1:42 PM, with LVN D, she stated Resident #5 has had some falls during his time at the facility. LVN D stated neurological checks were done when a physician orders them, or the nurse follows the facility protocol. LVN D stated if the resident hits their head or was assessed and did not pass the neuro checks, or a change of behavior was seen then not doing a neurological check could be a risk in which the resident could have a stroke or pass away. Resident #5 Record review of Resident #5's face sheet dated 04/03/24, revealed, admission on 08/23/19 and re-admission on 03/31/24 to the facility. Record review of Resident #5's facility history and physical dated 01/22/24, revealed a [AGE] year-old male diagnosed with Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), cataracts (a clouding of the lens of the eye, which is typically clear), osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes), and seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain). Record review of Resident #5's Nursing Home discharge MDS dated [DATE], revealed, no BIMS score was taken to assess cognitive recall. Resident #5's activities of daily living revealed dependent on nursing staff for personal hygiene and shower, and substantial/maximal assistance of nursing staff for dressing and toileting. Resident #5 was diagnosed with muscle weakness and lack of coordination. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's care plan dated 03/30/24, revealed, Resident sustained a fall. Care plan dated 03/14/24, revealed, history of falling due to immobility, muscle weakness, and decreased cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Care plan dated 01/24/24, revealed, at risk for falls and at risk for injury related to history of falls. Record review of Resident #5's orders dated 03/26/24, revealed, at risk for falls. Record review of Resident #5's incident/accident investigation worksheet dated 03/13/24, revealed, Resident #5 was found on the floor in the dining area with no apparent injury. Resident #5 expressed pain at 2/10, pain scale, and pain medication was given. Behavior/cognition - restless. No neurological checks flow sheet was completed for Resident #5 as per facility protocol/policy . During an interview on 04/03/24 at 3:43 PM, with ADON G, he stated neurological checks were done for unwitnessed falls or head injury. ADON G stated not doing a neurological check could result in the resident having subdural hematoma (a collection of blood between the covering of the brain (dura) and the surface of the brain) that presses on the brain. ADON G stated it was expected for the nurses to be doing neuro checks on unwitnessed falls or a head injury. Record review of facility Neurological Checks (Neuro Checks) policy dated 07/01/16, revealed, The licensed nurse will perform neurological checks following any type of actual or suspected head injury or for changes in level of consciousness. Documentation was completed on the Neurological Evaluation Flow Sheet, via the Glasgow Coma Scale (used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients). Follow directions on the form and reference for accurate scoring. Record review of the facility Fall Management policy dated 05/05/23, revealed, the facility will identify each patient/resident who was at risk for falls and will plan care and implement interventions to manage falls. The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights and highest practicable level of function. Neurological evaluations will be performed for a resident who sustains an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident. Record review of the facility Fall Management policy dated 05/05/23, revealed, the facility will identify each patient/resident who was at risk for falls and will plan care and implement interventions to manage falls. The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights and highest practicable level of function. Neurological evaluations will be performed for a resident who sustains an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident.

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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** 45217 Based on interviews and record review the facility failed to ensure that the residents environment remains free of accidents hazards as was possible and each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents and hazards. The facility failed to use the Hoyer lift (a patient lift used by caregivers to safely transfer patients) to transfer Resident #1. The noncompliance was identified as past noncompliance. The noncompliance began 02/20/24 and ended on 02/21/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of having an improper transfer used on them. Findings included: Record review of Resident #1's face sheet dated 04/02/24, revealed, admission on 01/29/21 to the facility. Record review of Resident #1's facility history and physical dated 12/15/23, revealed, an [AGE] year-old female diagnosed with chronic pain (long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition, such as arthritis), Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), Alzheimer's (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and delusional behaviors (one or more firmly held false beliefs that persist for at least 1 month). Resident #1's plan was for fall precautions. Record review of Resident #1's annual MDS dated [DATE], revealed, a moderate cognition to be able to recall or make daily decisions, BIMS (used to get a quick snapshot of how well you are functioning cognitively) score of 11 . Resident #1's activities of daily living require that she was dependent (helper or facility staff does all of the effort - Resident does none of the effort to complete the activity or the assistance of 2 or more helpers (facility staff) was required for the resident to complete the activity) on facility staff for eating, hygiene, shower, toileting, and dressing. Resident #1 was also dependent on toilet transfers, chair to bed and bed to chair transfers, sit to lying, roll left/right, and tub/shower transfers. Resident #1 has functional limitations on upper and lower extremities on both sides. Resident #1 was not marked for mechanical lift. Resident #1 was diagnosed with Quadriplegia (a form of paralysis that affects all four limbs, plus the torso), Non-Alzheimer's Dementia (a variety of disorders characterized by pathological changes involving various cortical and subcortical circuits), and Psychotic Disorder (affect brain function by altering thoughts, beliefs, or perceptions). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's orders dated 02/29/21, revealed, Risk: Falls - Transfer with assist of Hoyer x2 (nursing staff). Record review of Resident #1's care plan dated 02/20/24, revealed, Resident #1 was at risk for falling related to contractures, cognitive impairment, and lack of safety awareness. Care plan dated 05/11/23, revealed, Resident #1 required assistance with activities of daily living. Record review of Resident #1's progress notes by LVN A dated 02/20/24 at 3:23 p.m., revealed, 06:50 AM, CNA B call LVN A for help. Observed CNA B holding Resident #1 with arm underneath bilateral axillary (affecting both armpits). Resident #1 assisted to floor by CNA B. LVN A and CNA B transfer Resident #1 back to bed. Head to toe assessment done. No apparent injury noted. LVN A asked Resident #1 what happened? Resident #1 stated, Estava tratando de banarme. Y me le resbale y se resbalo la [NAME]. Entonces vino la enfermera a alludar. Vino CNA B [NAME] y ocasiono la caida (Spanish to English - I was going to take a shower. I slipped and the shower chair slipped. Then the nurse came to help. The CNA B came by herself and broke my fall.). LVN A notify ADON, DON, NP. Record review of Resident #1's Situation, Background, Assessment, and Recommendation dated 02/20/24, revealed, witness fall. Resident assisted Resident #1 to the floor. Things that make the condition or symptoms worse were - Resident #1 quadriplegic, max assist. Things that make the condition or symptom better were - Proper transferring. Primary diagnoses of fusion of spine, cervical region. During an interview on 04/02/24 at 3:45 PM, with Resident #1, she stated CNA B was going to take her to a shower. Resident #1 stated usually it was two staff that go in the room and transfer her using the Hoyer lift. Resident #1 stated CNA B grabbed her from the bed and tried to sit her down on the shower chair when the shower chair moved. Resident #1 stated she fell and hit her head backwards. Resident #1 stated she grabbed CNA B and CNA B grabbed her back. Resident #1 stated she had hurt her neck and head, but CNA B wanted to keep showering her. Resident #1 stated CNA B had not called for LVN A. Resident #1 stated she was not assessed by nursing staff. During an interview on 04/03/24 at 10:50 AM, with CNA B, she stated Resident #1 was a Hoyer lift transfer. CNA B stated she was not thinking when she transferred Resident #1, as one person transfer for a shower. CNA B stated she was aware that Resident #1 was a two-person Hoyer lift transfer and still transferred Resident #1 by herself. CNA B stated she though it was easy to just pick up Resident #1 with the gait belt and when she did Resident #1's legs gave out. CNA B stated Resident #1 never touched the floor she had placed her on the bed and then again tried to put her on the shower chair with no other staff help. CNA B stated when she tried again the shower chair moved when she called for LVN A. CNA B stated LVN A assessed her on the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/24 at 2:57 PM, with the DON, she stated Resident #1 was a two-person Hoyer lift transfer. The DON stated Resident #1 needed max to total assistance with all activities of daily living. The DON stated CNA B attempted to transfer Resident #1 to the shower chair. The DON stated the shower chair moved. The DON stated Resident #1 was a two-person Hoyer lift transfer. The DON stated LVN A had assessed Resident #1 on the floor in her room. The DON stated there were no injuries noted. The DON stated Resident #1 did not tell her she had hit her head. The DON stated CNA B was trained on how to do the transfers and did not do the appropriate transfer for Resident #1 which was a two-person Hoyer lift transfer. The DON stated there was a risk to Resident #1 of injury or falling. The DON stated CNA B was placed on suspension pending the outcome of the investigation which determined to be confirmed. The DON stated CNA B was re-trained on transfers, written up, and the facility identified CNA B had done something wrong. The DON stated CNA B had told her she was dumb, did not know what she was thinking, and that Resident #1 was a Hoyer lift transfer. During an interview on 04/04/24 at 10:33 AM, with the DOR , she stated Resident #1 was a two-person Hoyer lift transfer. The DOR stated Resident #1 needs a lot of assistance from maximum to total assistances for everything (activities of daily living). The DOR stated on 01/30/24, Resident #1 was evaluated by occupational therapy and found to have a decrease of Range of Motion. The DOR stated the purpose of the two-person Hoyer transfer for Resident #1 was that there was no functional use of Resident #1's extremities. The DOR stated it would never be appropriate to do a one-person transfer on a two-person Hoyer lift transfer. The DOR stated this was for safety of the residents and staff. The DOR stated the risk to the resident would be dislocation of limbs and/or physical injury to head or body. During an interview on 04/04/24 at 11:08 AM, with LVN A, she stated she heard CNA B yelling for her help. LVN A stated CNA B called to help her transfer Resident #1 with the Hoyer lift. LVN A stated Resident #1 was a two-person Hoyer lift transfer. LVN A stated when CNA B had told her she was going to shower Resident #1, she thought she had the Hoyer lift with her, and that was why she was calling for her help. LVN A stated she entered the room and saw CNA B holding Resident #1 underneath her arms and was not seen holding the gait belt. LVN A stated Resident #1 needed the Hoyer lift because Resident #1 was a quadriplegic. LVN A stated Resident #1 did not mention that she was in any pain or that she had hit herself on anything. LVN A stated CNA B had told her the shower chair slipped as she was trying to sit Resident #1 on it. LVN A stated she did not check to see if the shower chair brakes were applied. LVN A stated the one-person transfer that CNA B was doing was not appropriate because Resident #1 was a two-person transfer. She stated there could have been a risk to Resident #1 of injury or fall. LVN A stated staff have been trained on transfers by therapy department and will not clear us if we do not do the transfer right. During an interview on 04/04/24 at 2:26 PM, with CNA C, she stated she had received training on transfers. CNA C stated the therapy department and supervisors train them on transfers. CNA C stated that a resident could be a Hoyer lift transfer because the resident might have a weak body or arthritis (inflammation or swelling of one or more joints). CNA C stated that a one-person transfer could not be used for a resident who needs a two-person Hoyer lift transfer because there could be a risk of an accident. Record review of CNA B Suspension Pending Investigation dated 02/20/24, revealed, Reason for suspension - Not following plan of care with transfers on a resident who was transferred to shower chair verses using a two-person Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Corrective Action Form - dated 02/21/24, revealed, Written Warning: Failure to adhere to policy and procedures in regards to a Hoyer lift and patient transfer to ensure safety of resident. Record review of CNA B's witness statement dated 02/21/24, revealed, El dia 20 de Febrero un insidente yo CNA B meti a banar a la senora Resident #1, le puse las frenos a la [NAME] de [NAME] y agarre a la senora Resident #1 y entonces se me movio la [NAME] de [NAME], y agarre a la senora Resident #1de los hombras. Y entonces le grite a LVN A la enferrera por ayuda y [NAME] me ayudo apones la en la [NAME] y la comadernas. [NAME] en ningun momento se [NAME] al piso. (Translation to English from Spanish - On February 20th there was an incident where I tried to shower Resident #1. CNA B put the brakes on the shower chair and CNA B grab Resident #1 and tried to put her on the shower chair and it moved. CNA B grabbed Resident #1 from her arms and yelled from LVN A. LVN A helped me put Resident #1 on her bed.) Record review of the facility Fall Management policy dated 05/05/23, revealed, the facility will identify each patient/resident who was at risk for falls and will plan care and implement interventions to manage falls. The fall management program includes education for staff in creative, functional strategies while recognizing patients/resident's rights, and highest practicable level of function. Assistive Devices - refers to any item (e.g., fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand-alone or overheard transfer lifts, canes, wheelchairs, and walkers, etc.) that was used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety. Record review of facility Mechanical Lifts: General Guidelines policy dated 03/27/17, revealed, the facility may employee the use of mechanical lifts to assist with transfers to ensure the safety of patients, residents, and staff. Mechanical lifts may be used for the enhanced safety of patients, residents, and staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection 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 one resident (Resident #4) of four residents observed for infection control. Resident #4's catheter drainage collection bag was left on the floor. This deficient practice could affect residents with catheters and could result in cross contamination of germs and could result in a urinary tract infection (a painful infection of the urinary system, which includes the kidneys, bladder, urethra, and ureters). The findings included: Review of Resident #4's face sheet dated 04/05/2024, revealed resident was admitted to the facility on [DATE]. Review of Resident #4's History and Physical dated 12/15/2023, revealed diagnoses to include hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation) and chronic kidney disease (longstanding disease of the kidneys leaving to renal failure). Review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident was rarely/never understood. Resident #4 with indwelling catheter. Review of Resident #4's care plan dated 4/5/2024 revealed Problem: Resident #4 requires an indwelling urinary catheter related to urinary retention. Interventions: Store collection bag inside a protective, dignity pouch. Do not allow tubing or any part of the drainage system to touch the floor. Observation and interview on 04/02/2023 at 11:16 a.m., revealed Resident #4 lying in bed with a drainage collection bag lying flat on the floor next to his bed. Resident #4 was asked about the drainage bag being on the floor and resident was unable to provide details and shrugged his shoulders in response. Observation on 04/02/2024 at 11:39 a.m., revealed Resident #4 lying in bed with the drainage collection bag lying flat on the floor on the floor outside of privacy bag next to his bed. During an interview on 04/02/2024 at 11:45 a.m., LVN A said she did not know why the drainage collection bag was on the floor. LVN A said the risk to the resident was infection control. LVN A said the drainage collection is expected to be upright and attached to the bed frame. LVN A said all CNAs and nurses who work in the hall are responsible to ensure drainage bag is positioned correctly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/2024 at 8:49 a.m., the DON said the drainage collection bag should never be left on the floor. The DON said the collection bag being on the floor was an infection control issue due to resident's risk of urinary tract infections. The DON said Resident #4 had not had any issues with urinary tract infections. The DON said that CNAs and Nurses were responsible to ensure that the collection bag was securely attached to the bed. Review of facility Infection Control policy revised 05/15/2023, reads in part the Purpose: to establish a facility wide program that incorporates a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Staff Development plan includes, Care of invasive devices, such as vascular access, urinary catheter, respiratory ventilators, and tracheostomies. Review of facility policy Catheter - Urinary Catheter, Cleaning and Maintenance policy dated 05/05/2023, reads in part Do not place the drainage bag on the floor, to reduce the risk of contamination, and catheter associated urinary tract infections (CAUTI).