

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Los Arcos Del Norte Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11169 Sean Haggerty El Paso, TX 79934	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to have a safe, clean , comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely for 4 (hall 100, hall 200, hall 300, hall 400) of 4 hallways reviewed for infection control in that:</p> <p>The facility failed to pick up the trash in the resident rooms and in the hallway(s).</p> <p>This failure could have placed residents at risk for of residing in an unsafe, unsanitary, and uncomfortable environment.</p> <p>Findings included:</p> <p>Observation of hall 100 on 01/28/25 at 8:11 AM, revealed the following:</p> <ul style="list-style-type: none"> *room [ROOM NUMBER] had trash (pieces of white paper(s) and a Styrofoam cup) on the floor, * room [ROOM NUMBER] had clear medical gloves on the floor, *room [ROOM NUMBER] had food on the floor, and *room [ROOM NUMBER] had 2 blue packets of sugar on the floor. <p>Observation of hall 200 on 01/28/25 at 8:15 AM, revealed in the following:</p> <ul style="list-style-type: none"> *room [ROOM NUMBER] had trash on the floor. *The nurse's station was a green piece of trash on the floor, and *room [ROOM NUMBER] had trash on the floor. <p>Observation of hall 300 on 01/28/25 at 8:25 AM, revealed in room [ROOM NUMBER] there was pieces of trash on the floor.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of hall 400 and interview on 01/29/25 at 8:21 AM, revealed room [ROOM NUMBER] had a bloody gauze and next to the medication cart on the floor was another bloody gauze. LVN I stated the bloody gauze should have been thrown away properly and not on the floor as it was an infection control issues. LVN I stated it was the responsibility of the nurses to ensure that biohazard material are disposed of properly.</p> <p>During an interview on 01/29/25 at 8:29 AM, with the Interim-DON, she stated bloody gauze and or biohazardous material should be disposed of by the nursing staff. The Interim-DON stated if trash was seen on the floor, it should be picked up by anybody. The Interim-DON stated any biohazard materials are to be picked up by the nursing staff followed by the housekeeping staff who are to be disinfecting. The Interim-DON stated housekeeping should be going room to room and ensuring they are clean. The Interim-DON stated the risk would be infection.</p> <p>Observation on 01/29/25 at 8:32 AM, revealed, on 100 hall there were pieces of white paper near the nurse's station on the floor.</p> <p>Observation on 01/29/25 at 8:35 AM, revealed, on 200 hall in room [ROOM NUMBER] a paper straw and other white pieces of paper were on the floor next to the bathroom and trash can.</p> <p>Observation on 01/29/25 at 8:48 AM, revealed, on hall 300 there were pieces of white paper on the floor near the medical records office in the hallway. In room [ROOM NUMBER] there were clear medical gloves on the floor and blue packets of sugar on the floor near the dining cart.</p> <p>During an interview on 01/29/25 at 8:59 AM, with Manager of Housekeeping, he stated from 7AM to 5PM, him and his housekeeping staff were responsible for the trash and spill that were not fluids of the residents. The Manager of Housekeeping stated biohazard material was to be picked up by the nursing staff and then housekeepers go in afterwards and disinfect the area. The Manager of Housekeeping stated outside of the hours that housekeeping was not at the facility the nursing staff were responsible for picking and cleaning. The Manager of Housekeeping stated it would not be good to have trash on the floor and he would not have it like that at his home. The Manager of Housekeeping stated it could be a risk of infection.</p> <p>Observation on 01/29/25 at 10:25 AM, in 400 hall room [ROOM NUMBER], there was no trash can in the room and a bag full of trash on the floor next to the door. Bag was tied and full of items.</p> <p>During an interview on 01/30/25 at 8:28 AM, with EX-DON, she stated housekeeping was responsible for picking up the trash unless it was fluid or biohazard, then the nursing staff would pick it followed by the housekeepers who would disinfect. The EX-DON stated she would not have trash laying around or bloody anything on the floor in her house.</p> <p>Observation on 01/30/25 at 8:48 AM, revealed, on 300 hall room [ROOM NUMBER] next to bed B on the floor was shreds of wet toilet paper on the floor.</p> <p>Observation on 01/30/25 at 8:59 AM, revealed, on 400 hall room [ROOM NUMBER] there was fast food trash on the floor with no trash can seen in the room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/30/25 at 9:35 AM, with RN E, she stated the facility staff should be throwing all trash into there appropriate cans. RN E stated doing resident care the CNAs were to be discarding any trash when they left the room. RN E stated if there was trash on the floor anyone can pick it up unless it was biohazard then the nursing staff would pick it up followed by the housekeeping to disinfect. RN E stated not throwing the trash or having bloody gauze on the floor could be a risk of infection.</p> <p>During an interview on 01/30/25 at 3:57 PM, with CNA F, he stated trash was to be picked up by housekeeping or anybody and spills like bio were to be picked up by nursing staff and any other kind of spill not bio anybody could pick up. CNA F stated it was bio he would pick it up and then tell housekeeping to go and disinfect. CNA F stated not picking up the trash from the floor or the spills could be infection and pests. CNA F stated he would not have it dirty at his house especially since his wife would not let him and it would not be right.</p> <p>During an interview on 01/31/25 at 1:45 PM, with NP D, he stated that trash on the floor or bloody gauze should be picked up and be thrown the trash. NP D stated he had not noticed if there was trash on the floor when he goes to the facility. NP D stated the risk would depend on the situation.</p> <p>Record review of the facility Environment that Preserves Dignity - Resident Right for Policy dated 11/01/17, revealed, policy - the facility staff will provide the patient/resident with the right to an environment that preserves dignity and contributes to a positive self-image.</p> <p>Creates a home-like environment for the patient/resident that includes: Clean, orderly, comfortable, safe environment.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to ensure that the MDS assessment accurately reflected the resident's status (use of bed rails) for 1 (Resident #1) of 4 residents reviewed for accuracy of MDS assessment.</p> <p>Resident #1's quarterly MDS dated [DATE], did not accurately reflect the residents' use of bed rails (enablers).</p> <p>This deficient practice could place residents at risk of not receiving adequate care.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 01/31/25, revealed, admission on 08/29/24 and re-admission on 09/29/24 to the facility.</p> <p>Record review of Resident #1's hospital history and physical dated 10/25/24, revealed, a [AGE] year-old male diagnosed with Dementia and falls.</p> <p>Record review of Resident #1's quarterly MDS dated [DATE], revealed, a severe impact cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #1's functional ability indicated to be independent to be able to roll left or right on bed, sit to lying, lying to sitting on side of bed. Supervision or touching assistance for toilet transfer. Resident #1 was not coded in Section P - Restraints and Alarms - for bed rail use.</p> <p>Record review of Resident #1's Orders reviewed on 01/27/25, revealed, there were not orders for bed rail use.</p> <p>Record review of Resident #1's Care Plan on 01/27/25, revealed, has impaired functional mobility and requires assistance with ADLs due to moderately/severely impaired decision-making skills. Bed rails use was not care planned in Resident #1's care plan.</p> <p>Observation on 01/29/25 at 10:16 AM, with Resident #1 who was observed as he was demonstrating how he turned on his right-side body and his wrist hit the bed rail (enabler). Resident #1 preformed a range of motion with rotating his wrist. Wrist was not swollen or red.</p> <p>During an interview on 01/29/25 at 3:40 PM, with the Interim-DON, she stated she did not see Resident #1 having it coded in the MDS assessment for bed rail (enabler) use. The Interim-DON stated she would have to go and check with the MDS department to see if it needed to be coded or not. The Interim-DON stated she did not know if there would be a risk.</p> <p>During an interview on 01/31/25 at 8:13 AM, with the EX-DON, she stated residents using a bed rails (enabler) should be coded in the MDS assessment. The EX-DON stated Resident #1 was using bed rails (enablers) and should have been coded for bed rail use. The EX-DON stated she did not know what the risk would be for not coding it.</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/25 at 1:42 PM, with the Nurse Assessment Coordinator, she stated the MDS department was responsible for generating the MDS assessments. The Nurse Assessment Coordinator stated the MDS department was responsible for ensuring the MDS assessments were accurate. The Nurse Assessment Coordinator stated that Resident #1 did not have in Section P - Restraints and Alarms coded for bed rail use. The Nurse Assessment Coordinator stated she did not know what the risk would be for not coding the bed rail in the MDS assessment.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to implement a comprehensive person-centered care plan for Resident #1's use of bed rails (enablers).</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 01/31/25, revealed, admission on 08/29/24 and re-admission on 09/29/24 to the facility.</p> <p>Record review of Resident #1's hospital history and physical dated 10/25/24, revealed, a [AGE] year-old male diagnosed with Dementia and falls.</p> <p>Record review of Resident #1's quarterly MDS dated [DATE], revealed, a severe impact cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #1's functional ability indicated to be independent to be able to roll left or right on bed, sit to lying, lying to sitting on side of bed. Supervision or touching assistance for toilet transfer. Resident #1 was not coded in Section P - Restraints and Alarms - for bed rail use.</p> <p>Observation on 01/29/25 at 10:16 AM, with Resident #1 who was observed as he was demonstrating how he turned on his right-side body and his wrist hit the bed rail (enabler). Resident #1 preformed a range of motion with rotating his wrist. Wrist was not swollen or red.</p> <p>During an interview on 01/29/25 at 3:40 PM, with the Interim-DON, she stated she did not see Resident #1 having it care planned for bed rail (enabler) use. The Interim-DON stated the purpose of a care plan was for everyone to know how to take care of the resident and their needs. The Interim-DON stated there would be a risk but would not know what the risk would be.</p> <p>During an interview on 01/31/25 at 8:13 AM, with the EX-DON, she stated residents with bed rail (enabler) use needed to have it care planned in their care plans. The EX-DON stated the purpose of a care plan was so nursing staff knew how to take care of the resident and plan of care for the resident. The EX-DON stated Resident #1 should have had it care planned. The EX-DON stated the MDS department was responsible for the care plan. The EX-DON stated not care planning the staff would not know how to properly care for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/31/25 at 1:42 PM, with the Nurse Assessment Coordinator, she stated the MDS department was responsible for generating the care plans. The Nurse Assessment Coordinator stated the purposes of a care plan was a story of the resident and the care the resident was receiving. The Nurse Assessment Coordinator stated the MDS department was responsible for ensuring the care plan was accurate. The Nurse Assessment Coordinator stated she did not see bed rails (enabler) in the care plan for Resident #1. The Nurse Assessment Coordinator stated not putting the bed rails (enablers) in the care plan could be a risk for the resident. The Nurse Assessment Coordinator stated the risk could be the nursing staff not knowing how to service the resident.</p> <p>During an interview on 02/03/25 at 9:01 AM, with NP B, he stated that it would have been required to have bed rails (enablers) care planned for Resident #1. NP B stated not care planning it could be a risk to the resident if they do not need it.</p> <p>Record review of the facility Care Plan Process, Person-Centered Care Policy dated 05/05/23, revealed, Policy - The facility will develop and implement a Vaseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care.</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 46998</p> <p>Based on the observation, interview, 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 #15) of 2 resident reviewed for accidents.</p> <p>CNA G and CNA H were observed 01/28/2025 using the mechanical lift to lift Resident #15 without engaging the brakes as the mechanical lift was observed moving slightly.</p> <p>This failure could affect residents who required the use of a mechanical lift for transfers, by placing them at risk of improper transfers resulting in injury.</p> <p>Findings included:</p> <p>Record review of Resident #15's face sheet dated 01/29/25, revealed, a [AGE] year-old male who was admitted on [DATE] to the facility. Resident #15 was diagnosed with muscle wasting, abnormalities of gait and mobility, lack coordination, muscle weakness, and paralytic gait.</p> <p>Record review of Resident #15's payment assessment MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 6 to be able to recall or make daily decisions. ADLs revealed extensive assistance requiring one staff to help resident with bed mobility and transfers.</p> <p>Observation and interview on 01/28/25 at 10:13 AM, with CNA G, CNA H, and Resident #15. CNA G and CNA H were observed using the mechanical lift to lift Resident #15 without engaging the brakes as the mechanical lift was observed moving slightly. CNA H stated therapy provided training on mechanical lift transfers which included proper procedures for lifting and lowering of residents, as well as ensuring the brakes were engaged on the mechanical lift. CNA G stated she had forgot to secure the brakes when lifting Resident #15. CNA H stated the risk could be a fall if the mechanical lift were to move or tip.</p> <p>During an interview on 01/31/25 at 1:52 PM, with EX-DON, she stated nursing staff were trained on using the mechanical lift. EX-DON stated staff were required to place the brakes on the mechanical lift when lifting the resident into the air. EX-DON stated this was so the mechanical lift would move and for the safety of the resident.</p> <p>Record review of the facility Mechanical Lifts Policy dated 05/05/23, revealed, Policy - the facility may employ the use of mechanical lifts to assist with transfers to ensure the safety of patients, residents, and staff.</p> <p>Perform safety check, prior to lifting. Double check position and stability of straps and other equipment prior to lifting.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to assess the resident for risk of entrapment from an enabler (bed rail) prior to installation or review the risks prior to installation for 1 (Resident #1) of 4 residents reviewed for enablers (bed rails).</p> <p>Resident #1 did not have a Bed Rail Assessment done to ensure the bed rails (enablers) were appropriate for the use of Resident #1's needs.</p> <p>Resident #1 did not have orders for the bed rail (enablers) use.</p> <p>This failure could place residents who have bed [NAME] (enablers) at risk of having inappropriate or unnecessary enablers in place increasing their risk of injury.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 01/31/25, revealed, admission on 08/29/24 and re-admission on 09/29/24 to the facility.</p> <p>Record review of Resident #1's hospital history and physical dated 10/25/24, revealed, a [AGE] year-old male diagnosed with Dementia and falls.</p> <p>Record review of Resident #1's quarterly MDS dated [DATE], revealed, a severe impact cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #1's functional ability indicated to be independent to be able to roll left or right on bed, sit to lying, lying to sitting on side of bed. Supervision or touching assistance for toilet transfer. Resident #1 was not coded in Section P - Restraints and Alarms - for bed rail use.</p> <p>Record review of Resident #1's Orders reviewed on dated 01/27/25, revealed, there were not orders for bed rail use.</p> <p>Record review of Resident #1's Care Plan reviewed on dated 01/27/25, revealed, has impaired functional mobility and requires assistance with ADLs due to moderately/severely impaired decision-making skills. Bed rails use was not care planned in Resident #1's care plan.</p> <p>Record review of Resident #1's Assessments dated 01/29/25 at 1:54 PM, revealed, there was no assessment done by either the nursing staff or the therapy department for bed rail (enabler) use for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility self-report dated 11/07/24, revealed, on 11/02/24, LVN A noted swelling to Resident #1's left wrist, during assessment of flexion and extension of wrist, Resident #1 complained of pain. LVN A notified NP B and received orders for stat x-ray and pain medication was given. Two x-rays were taken and revealed a fracture to the distal ulnar styloid with minimal callus and mild displacement. Resident #1 was sent to the ER and received CT scan and MRI examination. Hospital findings revealed no evidence of acute displaced fracture. Irregularity of the distal ulna suggested for sequelae of remote chronic fracture. Facility self-report to state agency. Facility investigation was unconfirmed.</p> <p>Observation and interview on 01/29/25 at 10:16 AM, with Resident #1, he stated he was able to use the bed rails (enablers) to get up on his own. Resident #1 stated no one had abused him or was mistreating him. Resident #1 stated he turned and when turning his wrist hit the bed rail (enabler) as he was trying to grab it to get up. Resident #1 stated it had got swollen and he notified the nursing staff who responded immediately. Resident #1 stated it was a lot better now and he felt fine. Resident #1 was observed as he was demonstrating how he turned on his right-side body and his wrist hit the bed rail (enabler). Resident #1 preformed a range of motion with rotating his wrist. Wrist was not swollen or red.</p> <p>During an interview on 01/29/25 at 3:40 PM, with the Interim-DON, she stated she did not see any orders for Resident #1, for bed rails (enablers). The Interim-DON stated there had to be orders for bed rail (enabler) use. The Interim-DON stated she did not see a bed rail assessment completed for Resident #1. The Interim-DON stated she would go and check to see if bed rail assessments have to be done.</p> <p>During an interview on 01/31/25 at 8:13 AM, with the EX-DON, she stated the residents using the bed rails (enablers) needed to have orders for use of the bed rails (enablers). The EX-DON stated she would not know the negative outcome of not having orders for bed rails (enablers). The EX-DON stated that residents did not need to have bed rail (enabler) assessments done for use of the bed rails (enablers). The EX-DON stated the purpose of a bed rail (enabler) assessment was to see if the resident would benefit from use of the bed rail (enabler). The EX-DON stated the bed assessments were to be done quarterly for long-term residents. The EX-DON stated Resident #1 did not have orders for bed rail (enablers) use nor a bed rail (enabler) assessment. The EX-DON stated it was the responsibility of the nursing to get the orders and assessments done.</p> <p>During an interview on 01/31/25 at 1:42 PM, with the Nurse Assessment Coordinator, she stated the nurses were responsible for conducting the bed rail assessment for residents to see if they need them or not. The Nurse Assessment Coordinator stated not doing the bed rails assessments could be a risk of entrapment to the resident(s) who have them. The Nurse Assessment Coordinator stated there were no orders for bed rails (enablers) and residents using bed rails (enablers) needed to have one. The Nurse Assessment Coordinator stated the nurses were responsible for getting the orders. The Nurse Assessment Coordinator state the risk was the resident might not need the bed rail (enablers).</p> <p>During an interview on 01/31/25 at 1:45 PM, with NP D, he stated that he never orders bed rails (enablers) as he knows they are listed as restraints. NP D stated if the bed rails (enablers) were used then it would require an order. NP D stated he has not seen them in the facility and would not feel comfortable with the residents having them as they are high risk. NP D stated having bed rails (enablers) or assistive devices could be a risk of injury.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Los Arcos Del Norte Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11169 Sean Haggerty El Paso, TX 79934	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility Bed Rails and Side Rails, Installation and Use Policy dated 05/05/23, revealed, Policy- the facility will attempt to use appropriate alternatives prior to installing a side or bed rail. The facility will ensure the correct installation, use and maintenance of bed rails/side rails when their use was determined to be appropriate for the patient/resident.</p> <p>The resident will be evaluated for the risk of entrapment prior to installation.</p> <p>Qualified staff will make the determination to implement bed rails/side rails based on the criteria outlined in the facility Restraint Policy.</p> <p>Qualified staff will assess the patient/resident for continued use of bed rails/side rails at least quarterly, annually and with significant change.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 (Resident #14) reviewed for pharmacy services.</p> <p>The facility did not provide Resident #14's Cilostazol (vasodilator medication) 100 mg tablet given two times a day on 12/21/24 per physician orders.</p> <p>These failures could place residents at risk for a delay in medication administration and could place residents at risk for medical complications due to missed doses.</p> <p>Findings include:</p> <p>Record review of Resident #14's face sheet dated 02/03/25, revealed, admission on 11/09/24 and readmitted on [DATE] to the facility.</p> <p>Record review of Resident #14's facility history and physical dated 12/20/24, revealed, an [AGE] year-old female diagnosed with Diabetes and hypertension.</p> <p>Record review of Resident #14's admission MDS dated [DATE], revealed, an intact cognition BIMS score of 15 to be able to recall and make daily decisions. Resident #14 was coded for hypertension. Resident #14 was not coded for any antiplatelet use nor anticoagulant use.</p> <p>Record review of Resident #14's orders dated 12/20/24, cilostazol tablet, 100 mg. Give twice a day. Start 12/20/24 and End on 01/15/25. For essential primary hypertension. Range was not given nor indicated to hold.</p> <p>Record review of Resident #14's Progress notes dated 12/21/24, revealed, that there was no mention of Cilostazol not being given or issues with giving the medication.</p> <p>Record review of Resident #14's MAR dated 12/21/24, revealed, that Resident #14 did not receive her medication, Cilostazol (a vasodilator that works by relaxing the muscles in your blood vessels to help them dilate (widen)) on 12/21/24. Comments revealed Not Administrated: Drug/Item unavailable.</p> <p>During an interview on 01/30/25 at 2:37 PM, with MA, she stated the comment of Not Administrated: Drug/Item unavailable in the MAR meant that the facility did not have the medication. MA stated she had let LVN C know that they did not have the medication for Resident #14. MA stated since it was long ago she did not remember what had happened after that.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Los Arcos Del Norte Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11169 Sean Haggerty El Paso, TX 79934	
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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>During an interview on 01/30/25 at 3:57 PM, with LVN C, she stated she did not remember who Resident #14 was due to residents always coming and going. LVN C stated when the MAs are giving medications to the residents and they find that they do not have one, they are to let the nurses know. LVN C stated the nurses would then look at the stat safe to and pull the medication from there. LVN C stated she was told several times by the Mas that they did not have the Cilostazol medication. LVN C stated if the stat safe did not have it I would have called the physician to see where we would have acquired the medication and put in a progress note. LVN C stated she did not remember what she did when she was notified.</p> <p>During an interview on 01/31/25 at 8:30 AM, with the EX-DON, she stated that nursing staff should be giving medications as ordered by the physician. The Ex-DON stated Resident #14 had a history of strokes. The Ex-DON stated if the resident was on blood pressure medication, then the risk could be an increase in blood pressure and stroke. The Ex-DON stated if the medication was not given then the nursing are to be documenting that and reason why. The Ex-DON stated if there was none on hand then they are to be reporting it to the physician to see what else can be given.</p> <p>During an interview on 02/03/25 at 9:01 AM, with NP B, he stated Cilostazol was a blood pressure medication and not giving it could make a difference with the resident. NP B stated nursing staff are to be reporting if there are no medications to the physicians to see what they could prescribe. NP B stated not giving medications as ordered could be a risk to the residents which depends on the situation.</p> <p>During an interview on 02/03/25 at 1:13 PM, with NP D, he stated if Resident #14 would have missed one or two doses of Cilostazol would not have had a significant issue but with all meds that are not given as order could still have an impact on the resident. NP D stated he was tracking and monitoring Resident #14 during her stay at the facility and saw no issues. NP D stated it was the responsibility of the nurses to be reporting any time there were no medications for the residents available.</p> <p>Record review of the facility Physician Orders Policy dated 05/05/23, revealed, Policy- the qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines.</p> <p>Record review of the facility Medication Management Program Policy dated 05/05/23, revealed, Policy- The facility implements a medication management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements.</p> <p>Licensed nurses will evaluate, assess, monitor, document and report the effectiveness of the medication regimen that includes all medications and supplements prescribed to treat illness, disease process, or enhance the patient's/resident's quality of life.</p> <p>Authorized staff must prepare, administer, and record the medications.</p> <p>Documentation of medications administered was completed according to State and Federal requirements.</p>		