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	03/14/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51012 Based on observation, interview and record review the facility failed to provide reasonable accommodation of resident needs and preferences for 2 of 10 residents (Resident #41 and #246) observed for call lights: - The facility failed to ensure Resident #41 had access to his call light which was lying on the floor at the foot of his bed. - The facility failed to ensure Resident #246 had access to his call light which was lying on the floor next to his bed. This deficient practice could affect the residents by not maintaining and/or achieving independent functioning, dignity, and well-being. Findings included: Resident #41 Record Review of Resident #41's Admission Record dated 3/11/25 revealed he was a [AGE] year-old male with an initial admission of 08/23/19 and a readmission on 10/16/24. His diagnoses included: Alzheimer's disease (a type of brain disorder that affects memory, thinking, and behavior), Attention and concentration deficit, history of falling, muscle weakness, Cognitive communication deficit, Orthostatic hypotension (a condition characterized by a drop of blood pressure when standing up after sitting or lying down), Unspecified lack of coordination, and Unspecified abnormalities of gait and mobility (unusual or patterns of movement or changes in the way a person walks or moves). Record Review of Resident #41's MDS dated [DATE] revealed a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. Record Review of Resident #41's Care Plan dated 3/11/25 revealed that resident was at risk for falls due to muscle weakness, impulsiveness, lack of coordination, abnormal gait, and cognitive impairment. The Care plan revealed interventions from staff included assessment and treatment for orthostatic hypotension, increased staff supervision with intensity based on resident need, and keep call light in consistent and repetitive place due to decreased vision to promote call light usage. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/11/25 at 9:16 AM revealed Resident #41's call light was on the floor at the foot of resident's bed and out of his reach. Resident #246 Record Review of #246's Admission Record dated 03/11/25 revealed resident was [AGE] year-old man that was initially admitted [DATE] and a readmitted [DATE]. His diagnoses included: bilateral primary osteoarthritis of knee (), generalized muscle weakness, unspecified dementia, and Spondylosis (degeneration of the vertebral column). Record Review of #246's MDS revealed a Brief Interview for Mental Status with a score of 5, indicating severe cognitive impairment. Resident #246 needed limited assistance with activities of daily living, and the staff were to provide guided maneuvering of limbs or other non-weight-bearing support. Record Review of #246's Care Plan last revised 12/11/24 revealed resident has a history of falling related to osteoarthritis of knees, weakness, and deconditioning. The interventions revealed nursing staff was to always keep the call light within reach of Resident #246. Observation on 03/11/25 at 9:15 AM revealed that Resident #246's call light was on the floor by the head of the bed and out of the resident's reach. Interview on 03/14/25 at 9:20 AM with CNA E revealed that all staff were responsible for ensuring call lights are within a resident's reach. CNA E stated CNA's have more direct care with residents, but any staff that present themselves in the resident's room were responsible for ensuring call lights are within reach of residents. He stated the risks for residents for not having their call light included not having the help the residents may need, the resident can have a fall, or a fracture. Interview on 03/14/25 at 10:01 AM with ADON revealed that all staff were responsible for keeping and monitoring the residents' call light stayed within the residents' reach. She stated call lights served residents to call for assistance to have their needs met. She stated the risks of residents not having their call light within reach included a potential fall for the resident. Interview on 03/13/25 at 3:09 PM with DON revealed all clinical staff that go into the room of the resident are responsible for ensuring call lights were within reach of the resident. She stated CNA's, nurses, ADON and DON, are responsible for monitoring for call lights staying within the resident's reach. DON stated the call light was for the resident to call for help when needed so if it was not in reach, the resident would be unable to get that help. She stated the risk of the call light not being within the resident's reach included the resident reaching for the call light and could fall. Record Review of facility's policy Call Lights, responding to last revised 05/05/23, in part, revealed: The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs; When leaving the patient or resident room, ensure the call light is placed within the patient's/resident's reach.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 of 12 residents (Resident #48 and Resident #146) reviewed for environment, including but not limited to receiving treatment and supports for daily living safely. The facility failed to ensure Resident# 48's belongings were not damaged when moved from rooms. Resident# 48's portable closet was broken by the facility staff and was not replaced. The facility failed to ensure Resident # 146 resided in a room with a homelike environment by aiding with personalization of the side of his room with personal items. These failures placed residents and staff at risk of living, working and visiting in an uncomfortable environment and a decreased feeling of well-being and satisfaction within their physical surroundings. Findings include: Resident # 48 Record Review of Resident # 48's Admission Record dated 01/22/2025 revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnosis included toxic liver disease with hepatitis, unspecified lack of coordination, personal history of COVID-19, muscle wasting and atrophy. Record Review of Resident # 48's quarterly MDS dated [DATE] reflected a brief interview for mental status score of 15 (cognitively intact). It revealed she required limited assistance with bed mobility and transfer. Record Review of Resident # 48's Care Plan created on 2/13/25 reflected Resident# 48's had to be oriented to changes in environment such as new furniture and room changes. It revealed Resident# 48 was having periods of moods and behaviors by refusing facility transportation to appointments and the staff needed to attempt non-pharmacological interventions and document interventions on the Behavior Monitoring Flow Record, Non-pharmacological interventions included meeting her physical needs, activity programs (music therapy, exercise, outdoor time), quiet time and rest (reducing disruptive stimuli), redirection/ reassurance, increased observation, validation, consistent caregivers and psychological services. It revealed that the facility needed to communicate with the resident and made sure Resident# 48 understood prior to beginning any task. The facility was to inform the resident of intent, offer verbal one step directions for tasks, maintain a calm and slow approach, to not argue with the resident and to allow extra time for her to communicate her needs. It stated the facility needed to notify families of changes in resident status or of new or escalated behaviors to get their input as to suggestions or recommendations of interventions and approaches. It stated Resident# 48 was at risk of negative outcomes of her psychological wellbeing related to difficulty in nursing home placement. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Observation and Interview on 03/11/25 at 10:22 AM, Resident# 48 stated her concerns of being moved from rooms without her consent and the facility breaking a portable closet that she had bought when her belongings were transferred from one room to the other. Resident# 48 said she had spoken to the Social Worker and asked to be moved to a different room. The Social Worker advised the resident she would discuss the possibility of moving her with the IDT (Inter Disciplinary Team). Resident# 48 explained one day after a doctor's appointment, she returned to the facility after 5:00 PM and her belongings had been moved to a different room. Resident# 48 stated she was upset because she had not been informed of the room changes and because she found her portable closet broken. Resident# 48 said she felt her rights had been violated for not including her on planning and making decisions as to when and where she was going to be moved. The portable closet was observed in Resident# 48's room. The closet had the resident's clothes hanging inside. The closet was bent to the front towards the opening of the plastic doors. In an interview on 03/12/25 at 02:12 PM with LVN I, she stated she was informed of Resident# 48's room change by the previous ADON in the month of January 2025 but did not recall the exact date. LVN I said after the resident's belongings were moved and she had come back from an appointment in the evening, Resident# 48 approached her and voiced she was upset that she was not notified about her transfer and from the facility touching her belongings without her being present. LVN I stated she apologized to the resident and told her she did not know the facility had not informed her about the transfer. LVN I said she reported Resident# 48's concerns to the ADON as she had been trained to do. LVN I stated the potential outcome of the facility transferring a resident to a different room without their consent could result in residents feeling angry and making them think the facility does not take them into consideration when making decisions. LVN I said Resident# 48 was alert and oriented and should have been included in making those decisions. In an interview on 03/12/25 at 02:39 PM with the Administrator, he stated he was not working for the facility when Resident# 48 was transferred to a different room. He stated he did not know if the resident was given notice prior to getting relocated. The Administrator said he had received a report at the end of February 2025 of Resident# 48's closet being broken when her belongings were moved, and he was going to replace it immediately. The Administrator stated he had not been able to replace the closet because he had to leave the facility for ten days. He stated the potential outcome of a resident not being notified or being able to participate in making decisions of when and where they will be moved could result in residents feeling like their opinion did not matter to the facility. In an interview on 03/12/25 at 03:26 PM with the DON, she stated that for room transfers, the residents or responsible parties needed to be notified before they are moved. The DON said the Social Worker would be responsible for handling a room change and would need to talk to the resident or their representative about the room transfer. The DON stated she had heard in a morning meeting some days ago that Resident# 48 had voiced concerns for not being taken into consideration when she was transferred to a different room and the resident being upset about a broken item. The DON said the Administrator and Social Worker stated during the morning meeting they would talk to Resident# 48 to address her concerns. The DON said that after that meeting, she did not hear anything else about the concerns expressed by Resident# 48 and she had assumed the concerns from the resident had been addressed. The DON said by the facility not including a resident on making decisions about transferring rooms, could result in them feeling angry and frustrated and feeling they do not matter to the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/12/25 at 04:07 PM with Social Worker L, stated that during a morning meeting she presented the request to relocate Resident# 48 to a different to the IDT and they approved the transfer. Social Worker L said that a day passed without the resident being moved so the following day at the 3:00 PM IDT meeting, she reminded the members of team about Resident# 48's transfer and requested an update. Social Worker L stated that the previous DON appeared to be frustrated and asked the IDT who would volunteer to move Resident# 48's belongings after the meeting was concluded and several members volunteered to complete the task, including Social Worker L. She stated that those who volunteered moved Resident# 48's belongings to a different room while she was out at a doctor's appointment and when the resident returned to the facility, she was informed of the transfer. Social Worker L said Resident# 48 became upset and expressed her concerns to her stating her rights had been violated for touching her belongings without her consent and for moving her without giving her notice. Social Worker L said Resident# 48 also reported to her that the portable closet in her room had been damaged during the transfer of her belongings and requested for it to be replaced. Social Worker L stated she agreed Resident# 48's right had been violated due to the facility's failure to follow their policies and procedures for room changes. Social Worker L stated moving a resident from rooms without them being notified or included in the process could lead to residents feeling angry, frustrated or disregarded. Record Review of the facility's Grievance Summary dated 1/17/25 completed by the Social Worker stated Patient would like to submit a formal grievance for having her room changed without notification. Patient reports her closet was also damaged by staff member during room change, due to it no longer standing straight, adding that it now slants to the side. Record Review of the Resident Rights document provided to Resident# 48 by the Ombudsman stated in part: You have the right to keep and use your own property if the property is not harmful to others. Examples of your personal property include . furniture . The facility must have policies to protect your personal property from loss, damage, theft, or misuse. Resident # 146 Record Review of Resident # 146's Admission Record dated 03/13/2025 revealed she was an [AGE] year-old male admitted on [DATE]. His diagnosis included unspecified dementia, anxiety, pain disorder exclusively related to psychological factors, Alzheimer's disease, attention and concentration deficit and cognitive communication deficit. Record Review of Resident # 146's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04 (severe cognitively impaired). It revealed he required limited assistance with bed mobility, transfers, eating and toilet use. Record Review of Resident # 146's Care Plan created on 3/11/25 reflected Resident# 146 wondered around the facility and entered other resident's private spaces. It stated the facility's approach as attempting to identify patterns of increased wandering when there were change of shifts or after his family had visited him. It stated Resident# 146 needed to be assessed for activities as a potential intervention. It stated the resident was having mood and behavior needs evidenced by periods of physical aggression. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 03/11/25 at 10:30 AM revealed Resident #146 was not in his, room [ROOM NUMBER]. The bed lacked linens, and the room was empty. There were no signs of residency except for snacks on the nightstand. The walls were bare, lacking any personal touches. In an interview on 03/11/25 at 2:43 PM with Resident #146, he stated it would be nice to have pictures or a plant in my room. The resident was confused and after the statement he walked away. In an interview on 03/12/25 at 01:58 PM with CNA H she stated that it was important for the residents to feel like their room was their home. She said it was the responsibility of all staff from the facility to ensure the residents felt comfortable and safe. She stated the potential negative outcomes of a resident living in a room without any personal items or personalization could result in the resident feeling lonely or as if they did not belong. In an interview on 03/12/25 at 02:19 PM with LVN I stated Resident #146 had been moved to his current room around January 2025. LVN I said she knew Resident #146 had dementia and to her knowledge, only a family member visited him about once a month. She stated she did not know why his room lacked personal items. LVN I said the potential negative outcome for not personalizing a resident's room could result on them feeling loneliness and feelings of not belonging. In an interview on 03/12/25 at 02:51 PM with the Administrator said he was familiar with Resident #146 but not with his room's details. The Administrator stated the lack of a homelike environment could potentially result in the resident feeling isolated and could contribute to his feelings of anxiety or depression. In an interview on 03/12/25 at 03:34 PM with the DON, she stated it was important for residents to have personal belongings so they felt at home and avoid seclusion. She did not know who was responsible for ensuring room personalization. The DON said she did not know Resident #146's room was bare and lacked personal items in the room. The DON said the potential negative outcome for the facility failing to ensure a resident's room looked homelike could result in them feeling isolated and for them to feel they did not belong in the facility. In an interview on 03/13/25 at 03:14 PM with Social Worker L stated that Resident #146 had been at the facility for two years. She said the resident was diagnosed with dementia, Alzheimer's, and was cognitively impaired. Social Worker L said that in her interactions with Resident #146, he voiced that he believed he was at work most of the time. She said the resident's family member visited twice a month, and Resident #146 carried photos of his family members in his pockets. Social Worker L said she had consulted with Resident #146's family member and had been able to corroborate the people in the pictures as his family members. Social Worker L stated she thought it would be good if he had those pictures posted on the walls of his room, as it could potentially help reduce his wandering behaviors. Social Worker L stated she believed the facility should encourage room decorations, and that not having a more personalized environment could lead to residents feeling alone, abandoned, or like they didn't belong. She said that by not personalizing the resident's room it could also contribute to wandering and promote anxiety and depression. On 03/13/25, Resident# 146's emergency contact and responsible party was attempted to be contacted for an interview at 2:49 PM and 3:25 PM without success. Identification and contact information were left in her voicemail and a call back was requested. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/14/25, Resident# 146's emergency contact and responsible party was attempted to be contacted for an interview at 2:21 PM without success. Identification and contact information were left in her voicemail and a call back was requested. Record Review of the facility's policy revised on 11/1/2027 titled Resident Room, Environmental, stated in part: The facility provides the resident/patient with an environment that preserves dignity, privacy and contributes to a positive self-image. Resident rooms are designed and equipped for adequate nursing care comfort and privacy for residents. Promoting and preserving resident independence and self-sufficiency should be considered when arranging the resident living space .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010 Based on, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident medical, nursing and mental and psychosocial needs for 1 (Resident #52) of 8 residents reviewed for care plans. -The facility failed to ensure Resident # 52's dialysis was addressed on her care plan. This failure could place the resident at risk for not having their individual needs met in a timely manner and communicated to provide and could result in injury and a decline in physical well-being. Findings included. Review of Resident # 52 face sheet, dated 03/13/2025, reflected an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Arteriovenous fistula, acquired, Atherosclerotic heart disease of native coronary artery without angina pectoris, and Essential (primary) hypertension. Review of Resident #52's Five Day Scheduled MDS, dated [DATE], reflected Resident #52 had a Brief interview for mental status score of 10 indicated moderate cognitive impairment. Special treatments, procedures and programs checked for dialysis (peritoneal dialysis). Review of Resident #52's orders revealed orders for Dialysis every Tuesday, Thursday, and Saturday. Order start date of 12/20/24. Review of Resident # 52's comprehensive Care plan dated 3/5/25 did not address dialysis. Interview on 3/15/25 at 2:38 p.m. with DON, she stated that dialysis should be included in the residents' care plan. She stated the MDS nurses were in charge of creating the care plan. She stated the purpose of the care plan was to let the staff know how to take care of the residents. Without the care plan, dialysis assessments might not have been done. Interview with MDS nurse on 3/13/25 at 3:27p.m. revealed that dialysis was not included in care plan because MDS did not trigger that care area. She was not certain if dialysis had to be included in the care plan. She stated as far as the fistula care, the nurses would know how to take care of it because it was included in the orders which the nurses could see. She stated nurses could relay message to CNAs when taking vitals for the resident about the fistula and where the blood pressure could and could not be taken, therefore there was no risk to resident for dialysis not to have been included in the care plan. Interview with Regional nurse on 3/14/25 at 9:55a.m. revealed that dialysis should have been included in the care plan. The purpose of the care plan was for the staff to know what kind of care to provide to the resident. She stated that dialysis care was seen by nurses in the order set and for CNA's could see what arm to use for blood pressure on resident profile, even though it was not included in care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Care Plan Process, Person- Centered Care dated 5/5/2023 reads in part, The facility will develop and implement a baseline 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 care. Procedure reads in part, The baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident including but not limited to initial goals based on admission orders, resident goals, physician orders, dietary orders, therapy services, and the PASARR recommendation if applicable.

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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** 51010 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 9 residents (Resident #43 and Resident #46) reviewed for nail care. The facility failed to trim Resident # 43 and Resident #46's fingernails. This failure could place residents at risk of cross contamination and skin scratches that could result in infection. Findings include: Resident #43 Record review of Resident #43 ' s face sheet dated 03/13/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included, Cerebral infarction, hemiplegia, unspecified affecting left nondominant side, muscle weakness and cerebral aneurysm. Record review of Resident #43 ' s admission MDS assessment dated [DATE] revealed a brief interview for mental status score of 15 (cognitively intact). Resident #43 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene (The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and Hands). Record review of Resident #43 ' s care plan dated 03/11/25 revealed impairments in mobility, upper body strength, and ability to perform activities of daily living (ADLs) independently. Interventions included Assist the patient with dressing and undressing, ensuring the left arm was not overexerted. Help with grooming (e.g., hair brushing, shaving) and bathing, using adaptive tools (e.g., long-handled brushes) for personal hygiene. Observation and interview on 03/11/25 at 8:57 a.m. Resident #43 had long fingernails about an inch longer than nailbed with dirt under her nails. She stated they did not hurt her nails, but she would like them trimmed. She stated since being admitted she had not been offered to have her nails trimmed. Resident #46 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46 ' s face sheet dated 03/13/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included generalized muscle weakness, age related cognitive decline, cognitive communication decline and aphasia. Record review of Resident #46 ' s MDS assessment dated [DATE] revealed a brief interview for mental status score of 04 (severe cognitive impairment). Resident # 46 needed partial assistance from another person to complete any activities such as self-care (bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury). Record review of Resident #46 ' s order list dated 03/13/25 revealed an order for nail check completed once a day on Sunday initiated on 02/12/2025. Record review of Resident #46's care plan dated 03/08/2025 did not reveal any care plan reflecting personal hygiene. Observation on 3/11/25 at 9:48 a.m. revealed Resident # 46 had long fingernails about an inch longer than nailbed. Interview on 3/13/25 at 2:38 p.m. with DON revealed that Sundays were for nail care, she stated that DON, ADON, CNAs and floor nurses were responsible for making sure that nail care was done for residents. She stated that if a resident was diabetic the nurse had to trim the nails and if they were not then the CNAs could do it. She stated that it does not have to be done specifically on Sundays, it was whenever the need was identified by staff or residents voiced the need. She stated that some female residents liked having long nails, but the staff was still supposed to clean keep fingernails clean. She stated that she could not remember the last time that staff were trained on providing nail care. She stated that long nails could lead to infection because bacteria can grow under long fingernails and residents touch food with their hands and put it in their mouths. Interview on 3/14/25 at 9:31 a.m. with LVN E revealed that nail care was provided every Sunday. He stated that residents are offered a nail trim, and if they did not want a nail trim, they were to clean the long nails. He stated that if the resident was diabetic, the CNA would have to let the nurse know to cut them, If the resident was not diabetic then the CNAs could carry out the task. He stated that Resident #46 tended to refuse nail care, he stated when residents refused, it was documented on their shower sheets and CNA would let nurse know about refusal. He stated residents with long nails were at risk for infections, hurting themselves by accidentally scratching themselves. Interview on 3/14/25 at 9:55 a.m. with regional nurse revealed that personal hygiene was provided on a regular basis, every time need was identified and if the resident/family voiced the need. She stated that some female residents preferred having long fingernails, but their nails were to still be kept clean. She stated refusals that were voiced to nurses were supposed to be documented in a progress note. She stated that residents with long nails could be at risk of infection because bacteria can get under fingernails and residents touch their face and eyes and mouth. Record review of facility policy Activities of Daily Living, Optimal Function dated 5/5/23 read in part, The facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming and hygiene.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51010 Based on observation, interview, and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 3 of 4 medications carts (Hall 100 medication cart, Hall 200 medication cart and Hall 300 treatment cart) reviewed for medication storage. -The facility failed to ensure liquid medication stored in medication cart did not have dried drippings on the sides of the bottles in the 100 Hall. - The facility failed to ensure the bottle of Betadine stored in the treatment cart and in medication cart (Hall 300) was free of dried drippings. -The facility failed to ensure a bottle of Chlorhexidine Gluconate solution stored in medication cart (hall 200) was free of dried drippings. This failure could result in drug diversion of controlled substances. These failures could affect residents that received medications at the facility by placing them at risk of not having prescribed medications and cross contamination. The findings included: An observation of the 200-hall medication cart on 03/12/25 at 11:11 a.m. revealed a bottle of Betadine Iodine and a bottle of Chlorhexidine Gluconate solution with dried drippings running down the side of the bottle. Hall 100 An observation of the 100-hall medication cart on 03/12/25 at 2:30 p.m. revealed a bottle of pro-stat liquid medication with dried drippings running down the bottle. An observation of the (hall #300) treatment cart on 03/12/25 at 11:37 a.m. revealed a bottle of Betadine Iodine with dried drippings running down the bottle. Interview on 3/12/25 at 2:30 p.m. with LVN B revealed that all medication bottles needed to be clean after each use because storing dirty bottles could lead to cross contamination. Interview on 3/13/25 at 9:30 a.m. with LVN A revealed all medication bottles needed to be clean. He stated they should be cleaned after every use before being put away. He stated since it was an iodine bottle, and since it is hard to keep clean because it runs everywhere, it was not a big deal. He stated that storing dirty bottles can lead to cross contamination. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/13/25 at 2:38 p.m. DON stated that medication bottles should have been stored up right and clean. She stated staff were trained to clean bottles after each use to prevent cross contamination. She stated that she was unsure of when the last training was done for staff. Interview on 3/14/25 at 9:55 a.m. with regional nurse revealed that medication bottles should be cleaned after each use. She stated that it was hard to keep bottles clean because Iodine stains easily and pro-stat medication was very sticky. She stated storing medication bottles like this would lead to cross contamination with other medications in the cart. Record Review of facility policy Medication Management Program dated 7/1/16 revealed no specific instructions on keeping bottles clean and free of dried drippings.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51012 Based on interview and record review, the facility failed to provide assistance to resident who required dental care for 1 of 8 residents (Resident #20) reviewed for dental services. The facility failed to assist in providing routine dental services for Resident #20. This failure could affect residents by placing them at risk for oral complications and diminished quality of life. Findings Included: Record Review of Resident #20's face sheet dated 03/13/25 revealed an [AGE] year-old female with admitted [DATE] and readmitted [DATE]. Her diagnoses included: disorder of tooth development and dysphagia (difficulty swallowing). Record Review of Resident #20's Annual MDS revealed a score of 15, indicating little to no cognitive impairment. MDS revealed Resident #20 was dependent for all ADL's, meaning helper does all the effort and resident does none of the effort to complete the activity. Record Review of Resident #20's Care Plan last edited 02/18/2025 revealed resident was limited in mobility/functional status. Interventions included for staff to provide assistance with oral care according to resident's ability. Record Review of Resident #20's record of treatment from most recent dental visit dated 05/28/24 revealed Resident #20 went in for emergency dental exam due to losing a crown. Resident #20 experienced sensitivity all over her mouth and her oral hygiene needed improvement., nurse reported to dentist that Resident #20 bleeds when facility staff brushed her teeth. Resident #20 required deep cleaning in a hospital setting due to Resident #20 being quadriplegic. During an interview and observation on 03/11/25 at 09:43 AM with Resident #20 revealed she had requested dental services from facility staff including nursing staff and the previous Administrator. She stated last dental visit was 05/2024 for an emergency dental exam. Resident #20's teeth observed clean, however, her gum appeared with a red lining surrounding her teeth. Interview on 03/14/25 at 09:20 AM with CNA E revealed Resident #20 has requested a face mask due to her teeth being sensitive. He stated he has observed her teeth as clean as nursing staff completely assist her with oral care. He stated oral care was completed every morning and night, and it was the responsibility of the resident and CNA's. He stated residents go out to the community for their dental services or the dentist comes into the facility. He stated the last dentist to come into the facility was 11/2024. CNA E stated nurses are responsible for monitoring dental visits. He stated the risks of not keeping up with routine dental appointments for residents included infections or wounds. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/25 at 03:01 PM with DON revealed Social Services were responsible for monitoring dental appointments. She stated there was a company that was contracted by the nursing facility for dental services and the dentist would come into the facility, but the DON was not sure how often they visited. She stated the risk of residents not having maintained routine dental appointments included infection. Interview on 03/13/25 at 03:45 PM with Social Worker L revealed she was responsible for sending a referral for dental services for residents if service was requested. She stated the last time she recalled seeing a dentist in the facility was 11/2024. Interview on 03/14/25 at 10:26 AM with Social Worker L revealed she was responsible for monitoring dental services, but she would get assistance from nurses on the floor. She stated nursing were to schedule dental appointments per the resident request. She stated the nurses would document a 24-hour report sheet for the next shift regarding residents if not verbally report to the next shift nurse. Social Worker L stated she had not received reported concerns or requests for dental appointments. She stated dental appointment requests or concerns would be discussed during their morning or afternoon meetings. She stated she was not sure how the facility monitored the effectiveness of dental services. She stated she was not sure how the facility monitored for dentist availability. She stated during quarterly care plan meetings for long-term residents, they are asked about questions on concerns for their care. She stated the risks for residents not receiving routine dental care included tooth decay or pain. Interview on 03/14/25 at 10:01 AM with ADON revealed cleaning and oral hygiene was the responsibility of direct care staff such as CNAs and nursing staff. ADON stated the facility had monthly dental services, which included long-term residents are served by a dentist in the facility and skilled residents are sent by a specialist. ADON stated nursing was responsible for monitoring dental services. In an interview on 03/14/25 at 10:40 AM with LVN N revealed nurses were responsible for scheduling and monitoring dental appointments. She stated residents were able to notify nurses of their request for dental appointment so nurses could find a dentist that would accept the resident's insurance. She stated routine dental appointments were to be done every 6 months. LVN N stated the risks for residents not having their routine dental appointments included infection or pain. Record Review of facility policy Medical, Vision, Hearing, and Dental Care Providers- Resident Rights for revealed in part: Upon admission the Facility will provide a list of medical and dental care providers available to the facility. Social Services staff or designee will provide the name, specialty, and contact information for chosen medical, vision, hearing, and dental care providers participating in care. Facility staff assist with or schedule appointments and transportation arrangements for medical, vision, hearing, and dental care, as necessary. Facility staff assists with interactions and communication with providers, being mindful of potential speech, language, hearing, vision or comprehension impairments.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 20026 Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 1 of 1 meal viewed for food temperatures. -The facility failed to maintain food hot on diet serve test trays. This failure could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: Observation and interview on 03/11/25 at 12:17 p.m., with the DON revealed a mobile Sheet Pan Rack covered with a clear trash plastic bag that contained lunch meal trays in the 200 Hall. When the state surveyor asked the DON, how was the food kept warm? The DON did not reply. Observation and interview 03/11/25 at 12:50 PM, with the DON revealed another mobile Sheet Pan Rack was in resident hallway covered with a clear plastic trash bag that contained lunch meal trays. The DON said the mobile Sheet Pan Rack were covered with a clear plastic trash bag to keep the meal trays warm. Interview on 03/12/25 at 12:00 p.m., with Dietary Manager said the mobile Sheet Pan Rack used to transport meal trays to the resident halls were covered with clear plastic trash bags to help keep the food hot in the meal trays. Sampling of the test trays on 13/14/25 at 12:17 p.m. through 12:29 p.m., in the conference room, with the Dietary Manager revealed the following: The Regular Diet Tray: *Pot Roast with brown, gray was 135-degree Fahrenheit; *Peas 133 degrees Fahrenheit; *Mashed potatoes with brown, gray was 123-degree Fahrenheit; *Cream Pie 19-degree Fahrenheit. The Mechanical Diet Tray: *Pot Roast with brown, gray was 133.7-degree Fahrenheit, *Peas 132.7-degree Fahrenheit; *Mashed potatoes with brown, gray was 131.5-degree Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pureed Diet Tray: Pot Roast with brown, gray was 125.9-degree Fahrenheit; *Peas 135.6-degree Fahrenheit; *Mashed potatoes with brown, gray was 124.7-degree Fahrenheit; *Bread 130.5-degree Fahrenheit. The Dietary Manager confirmed that several of the temperatures on the test trays were cold. She said foods that are below the required temperature will be reheated for 15 seconds in the microwave or until the food was reheated to 165 degrees Fahrenheit prior to serving to the residents. The Dietary Manager said the facility only had 2 insulated meal carts and 2 metal meal carts since she started working at the facility in 2021. She said that occasionally the residents in the 300 and 400 halls complained that food was served cold. She said, The food might get cold, depending on when the CNAs pass out the meal trays. She said that hot foods should be 140-164-degree Fahrenheit and cold food below 40-degree Fahrenheit. Review of facility's policy and procedures on Safe Food Handling dated 06/20/2023 revealed, Subject: Safe Food Handling. Policy: Food acquisition, and distribution will comply with accepted food handling practices. Food/Beverages Prepared and Served by Facility Staff for Patients or residents: All food are stored, prepared, and served at temperatures that prevent bacterial growth. Hot foods are maintained at 135 degrees Fahrenheit or higher and cold foods are maintained at 40 degrees Fahrenheit or below at point of service. At point of delivery, hot foods and cold foods should be palatable and consumed within 2 hours or discarded.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20026 Based on observations, interviews, and record 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. -The facility failed to ensure the kitchen staff used beard restraints to prevent food contamination. -The facility failed to keep a deep fryer covered, free of food particles and burnt oil. -The facility failed to store opened food containers in the food preparation area and dry storage room in sealed containers. -The facility failed to label, and date opened foods stored in the dry storage room and refrigerator. These failures could place residents at risk of food borne illnesses. Findings included: Observation on 03/11/25 at 7:50 a.m. with the Dietary Manager revealed [NAME] D had a short beard and no beard restraint while he was serving breakfast. The Deep Fryer was uncovered, contained burnt oil and the deep fryer basket had food particles around the edges; white plastic container labeled Thickener stored in the food preparation area was not completely sealed; opened thickened milk container stored in the refrigerator was not dated; opened bag of noodles stored in a plastic bag that was not sealed; opened box of tea that was not dated when opened; large bag of peeled garlic bulbs stored in a plastic bag that was not sealed; Hashbrown and Potato bags stored in refrigerator were not dated; bag of cauliflower was not dated. The Dietary Manager said dietary staff had been trained to store opened food containers in sealed plastic bags or sealed plastic food containers to prevent food contamination to prevent exposing the food to dust, and pests. The Dietary Manager said dietary staff had also been trained to label and date food containers when food was removed from the original containers and to date food containers upon delivery and when opened. Observation on 03/13/25 at 7:50 a.m., revealed [NAME] D was serving breakfast and did not have a beard restraint. The Dietary Manager was in her office located in the kitchen directly across the serving line and cook preparation without a hairnet, while the cook was serving breakfast. In an interview on 03/13/25 at 10:24 a.m., the Dietary Manager said the dietary staff had been trained 4 months ago on the importance of using hairnets and beard restraints while working in the kitchen to prevent hair from contaminating food and food-contact surfaces, thereby ensuring food safety and hygiene. Observation 03/13/25 at 10:51 a.m., [NAME] D revealed he was preparing food in the food preparation area, by the serving line without beard restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/13/25 at 10:57 a.m., [NAME] D revealed he had been employed at the facility for 7 months and he had been trained to use hairnets and beard restraints when working in the kitchen to prevent food contamination. He said I use a beard cover most of the time. I have not had time to shave off the beard, so I don't have to use a beard cover. He said the dietary staff had been trained to put opened food containers in sealed plastic bags and/or sealed plastic containers to prevent food contamination. Record review of the Food Code 2022 reflected the following: (C) Packaged Food shall be labeled as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. 3-202.15 Package Integrity. Food packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. Record Review of the facility's Policy and Procedure on Food Safety in Receiving and Storage dated 06/20/23 revealed, General Food Storage Guidelines: Store food in its original packaging is clean, dry, and intact. Place food that is repackaged in leak-proof, non-absorbent, sanitary container with a tight-fitting lid. Dry Storage Guidelines: Tightly seal opened packages to prevent contamination or place food in covered containers. Refrigerated Storage Guidelines: Separate unwashed produce from washed fruits and vegetables and other ready to eat foods. Refrigerated, ready to eat foods are properly covered, labeled, dated with a use-by-date, and refrigerated immediately. Review of the facility's policy and procedures on Safe Food Handling dated 06/20/2023 revealed, Subject: Safe Food Handling. Policy: Food acquisition, and distribution will comply with accepted food handling practices. Food/Beverages Prepared and Served by Facility Staff for Patients or residents: General Requirements: Anyone working in the kitchen during normal food preparation hours are expected to wear appropriate hair restraints (such as hats, hair covers or nets, beard restraints).

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on interviews and record review the facility failed to ensure a facility with more than 120 beds employed a qualified social worker on a full-time basis. The facility failed to have a full-time social worker since [DATE]. This failure could have placed residents in need of social services at risk of psycho-social decline and poor-quality of life. Findings included: Record review of the Facility Summary Report revealed the facility was licensed for 124 bed capacity. Interview and record review on [DATE] at 4:00 PM, with the HR/Payroll Coordinator revealed the temporary Social Worker permit for Social Worker L had expired on [DATE]. The HR/Payroll Coordinator stated, We have 2 social workers; Social Worker L works at this facility and Social Worker M, works at a sister facility . Record review on [DATE] at 9:05 AM of the Resident's care plans for seven sampled residents, revealed Social Worker L continued to provide services by updating and participating in care plans for the residents in the facility with the last update performed on [DATE]. In an interview on [DATE] at 09:22 AM with Social Worker L, she stated there were no other social workers in the building at that time. Social Worker L stated Social Worker M also worked for the facility but she was not a full-time employee. She stated she did not know when Social Worker M would be at the building to supervise her work or provide oversight. In an interview on [DATE] at 09:48 AM with the Regional Nurse, she stated she did not know that Social Worker L's license had expired since [DATE]. The Regional Nurse said she would contact the Human Resources department and inquire about Social Worker L's expired license. She stated the potential outcome for residents being assessed by a Social Worker with an expired license could result in delay for services for the residents or for them to not be properly assessed by a licensed professional. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 01:29 PM with Social Worker L, she stated her social work license expired on [DATE]. Social Worker L said the national director of social services and the regional vice president for the company Fundamental, the owner of the facility, were aware of the situation. Social Worker L said the previous administrator also knew. Social Worker L was unsure if the interim administrator or the interim DON were aware. Social Worker L stated the Regional Nurse, was believed to know, as she was present during a conversation between Social Worker L and the regional vice president when they discussed her expired license. Social Worker L stated she continued to provide services despite knowing she shouldn't with an expired license, citing a lack of other social workers at the facility. She believed Human Resources were responsible for ensuring licenses were current and that department should have taken measures to ensure the facility did not go without the services of a licensed Social Worker. Social Worker L stated she did not know the potential negative outcomes of working without a license, as she believed her knowledge remained the same. She was also unaware of the potential consequences for her license for continuing to work with an expired license. Record Review on [DATE] at 1:35 PM of an email sent by Social Worker L on Thursday [DATE], at 5:22 PM revealed she informed the national director of social services that the previous Administrator for the facility had advised her to inform her license had expired on [DATE]. Social Worker L stated in her email that the facility had decided to keep her working, and that she would register to take her licensure exam after the required three months from failing her first exam on [DATE]. Social Worker L's email received a response from the National Director of Social Services stating she was in agreement with Social Worker L's retesting and that the facility would have to have a licensed Social Worker covering the facility. On [DATE], The Interim Administrator, Interim DON, and the HR Payroll Coordinator reported sick and did not attend work. Their statement was not able to be obtained. Record Review of the facility's policy and procedures revised on [DATE] stated in part: Employment Standards, Education. Educational and licensure requirements are based on facility, location, and state regulation. Must possess, as a minimum, an associate's degree in a human services field or related social services experience.

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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** 51012 Based on observation, interview, and record review, it was determined the facility failed to ensure a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 resident (Resident #13) reviewed for incontinent care. CNA G failed to perform hand hygiene after disposing dirty briefs and before putting on new clean briefs for Resident #13. This practice had the potential to affect residents identified by the facility as incontinent of bladder by putting them at risk for skin breakdown, cross contamination, and urinary tract infections. Findings include: Record Review of Resident #13's face sheet dated 03/13/25 revealed an [AGE] year-old female with admitted [DATE] and readmitted [DATE]. Her diagnoses included: unspecified dementia, Alzheimer's disease (neurological disorder that causes irreversible changes in memory, thinking, and behavior), generalized muscle weakness, and cognitive communication deficit. Record Review of Resident #13's MDS dated [DATE] revealed a Brief Interview for Mental Status with a score of 2, indicating severe cognitive impairment. MDS revealed Resident #13 needed extensive assistance with toileting, meaning the resident was involved in the activity and one staff was to provide weight-bearing support. Record Review of Resident #13's Care Plan last revised 01/20/25 revealed resident required assistance with ADLs with the goal of resident maintaining a sense of dignity by being clean, dry, and odor free. The Care Plan revealed intervention of staff assist of 1 for toileting. During an observation on 03/13/25 at 09:57 AM of CNA G performing perineal care on Resident #13 revealed she disposed dirty wipes and dirty gloves and put on new gloves without performing hand hygiene. CNA G proceeded to wipe Resident #13's buttocks and disposed dirty wipes and gloves and put on new gloves to place new briefs on Resident #13 without performing hand hygiene. In an interview on 03/13/25 at 10:08 AM with CNA G revealed the facility has in-service training for perineal care monthly. She stated the most recent in-service training was 2 days ago She stated the risks of not performing hand hygiene after disposing soiled wipes and gloves and before putting on new gloves and briefs included infection control issues. In an interview on 03/13/25 at 2:34 PM with DON revealed nursing staff was to perform hand hygiene before dirty to clean wipes, gloves, and the new brief. She stated the risk of not performing hand hygiene in between dirty to clean included cross contamination which can cause infection. She stated she would have to check records to confirm the last in-service for perineal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/14/25 at 10:01 AM with ADON revealed that hand hygiene should be done before and after perineal care. She stated hand hygiene was to be done after disposing soiled brief and before placing the new brief. She stated the risks of nursing staff not performing proper hand hygiene included cross contamination which is an infection control issue. ADON stated the resident can contract infections as a result. ADON stated the nursing staff providing perineal care was responsible for performing proper hand hygiene. Record Review of facility's policy Perineal and Incontinence Care, last revised 05/05/23, revealed: Staff will perform perineal/incontinent care with each bath and after each incontinent episode. Policy procedure notated reference: Lippincott Nursing Procedures, 9th Ed., Perineal Care, pages 651-653. Record Review of Lippincott Nursing Procedures, 9th Ed., Perineal Care, pages 651-653 read in part, revealed: Dispose of soiled articles receptable; Remove and discard your gloves, gown; Perform hand hygiene.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 20026 Based on interviews and record review the facility failed to include effective communication as a mandatory training for direct care staff for 7 of 12 staff (Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, [NAME] D, and LVN A) reviewed for training on effective communication. The facility failed to ensure direct care staff received training on effective communication for the Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, [NAME] D, and LVN A. This failure could place residents at risk of not having a way to effectively communicate their wants or needs. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the State Surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information . Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware the ADON still had not provided the training records for review that had been requested on 03/13/25 by the State Surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with Corporate Regulatory Specialist informed the State Surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit . (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the User Learning Records dated 03/14/25 documentation of trainings provided by the ADON and the Corporate Regulatory Specialist revealed the following employees had not completed training on effective communication: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, ADON hired 03/03/25, LVN I hired 08/20/24, [NAME] D hired 10/15/24, and LVN A re-hired 02/17/25.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 20026 Based on interviews and record review the facility failed to ensure that all staff members were educated on the rights of the resident and the responsibilities of a facility to properly care for its residents for 8 (Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, Social Worker L, [NAME] D, and LVN A) of 12 employees reviewed for training on the rights of the resident and the responsibilities of a facility to properly care for its residents. The facility failed to ensure the Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, Social Worker L, [NAME] D, and LVN A, received training on the rights of the resident and the responsibilities of a facility to properly care for its residents. This failure could put residents at increased risk of not having their rights respected or not receiving proper care. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the State Surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information . Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the State Surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the State Surveyor with the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with Corporate Regulatory Specialist informed the State Surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit . (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the User Learning Records dated 03/14/25 provided by the ADON and the Corporate Regulatory Specialist revealed the facility did not have documentation for the following employees on the rights of the residents: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, ADON hired 03/03/25, LVN I hired 08/20/24, Social Worker L hired 1/04/24, [NAME] D hired 10/15/24, and LVN A re-hired 02/17/25.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 20026 Based on interviews and record review, the facility failed to provide the required annual or new hire abuse training including all activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property, dementia management, and resident abuse prevention for 8 of 12 employees (Interim Administrator, Interim DON, Med Aide J, RN K, ADON, [NAME] D, LVN A, and Social Worker M) reviewed for Abuse and Dementia training. -The facility failed to ensure abuse training including activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property, Dementia management, and resident abuse prevention was provided to Interim Administrator, Interim DON, Med Aide J, RN K, ADON, [NAME] D, LVN A, and Social Worker M upon hire and annually. This failure could affect residents and place them at risk of abuse due to lack of staff training. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the state surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information. Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the state surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor with the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 03/14/25 at 5:07 PM, with Corporate Regulatory Specialist informed the state surveyor that they had not found training records for the staff, and they had attempted to put together training records, They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit. Record review of the User Learning Records dated 03/14/25 provided by the ADON and the Corporate Regulatory Specialist revealed the facility did not have documentation for the following employees on Abuse , Neglect & Exploitation and Dementia training: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, RN K hired 11/30/23, ADON hired 03/03/25, Social Worker M hired 1/19/23, [NAME] D hired 10/15/24, and LVN A re-hired 02/17/25.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 20026 Based on interviews and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program for 12 (Interim Administrator, Interim DON, Med Aide J, RN K, ADON, LVN I, Social Worker L, [NAME] D, LVN A, Maintenance, Social Worker M, and the Dietary Manager) of 12 employees reviewed for QAPI training. The facility failed to include trainings regarding the facility's QAPI program in its training for employees. This failure put residents at risk of receiving poor-quality services because of staff being unaware of quality control concerns the facility was working to address. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the state surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information. Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the state surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor with the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with the Corporate Regulatory Specialist informed the state surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the User Learning Records dated 03/14/25 provided by ADON and Corporate Regulatory Specialist revealed the facility did not have documentation for the following employees on QAPI Program: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, RN K hired 11/30/23, ADON hired 03/03/25, LVN I hired 08/20/24, Social Worker L hired 11/04/24, [NAME] D hired 10/15/24, LVN A re-hired 02/17/25, Maintenance hired 11/17/17, Social Worker M hired 01/19/23, and Dietary Manager hired 12/06/21.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 20026 Based on interviews and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 11 of 12 staff (Interim Administrator, Interim DON, Med Aide J, RN K, ADON, LVN I, [NAME] D, LVN A, Maintenance, Social Worker M, and the Dietary Manager) reviewed for training. The facility failed to ensure an infection prevention and control training was provided to the Interim Administrator, Interim DON, Med Aide J, RN K, ADON, LVN I, [NAME] D, LVN A, Maintenance, Social Worker M, and the Dietary Manager. This failure could place residents at risk of illness due to lack of staff training. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the state surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information. Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the state surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor with the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with Corporate Regulatory Specialist informed the state surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the User Learning Records dated 03/14/25 provided by the ADON and the Corporate Regulatory Specialist revealed the facility did not have documentation for the following employees on Infection Prevention: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, RN K hired 11/30/23, ADON hired 03/03/25, LVN I hired 08/20/24, [NAME] D hired 10/15/24, LVN A re-hired 02/17/25, Maintenance hired 11/17/17, Social Worker M hired 01/19/23, and Dietary Manager hired 12/06/21.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 20026 Based on record review and interviews, the facility failed to ensure all staff received training in compliance and ethics for 8 of the 12 staff members (Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, COOK D, LVN A, and Social Worker M) reviewed for mandatory training. The facility failed to ensure an ethics training was provided to Interim Administrator, Interim DON, Med Aide J, ADON, LVN I, COOK D, LVN A, and Social Worker M. This failure could place residents at risk of receiving inadequate care from staff who are uneducated on compliance and ethics. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the state surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information. Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the state surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor with the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with Corporate Regulatory Specialist informed the surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit. Record review of the User Learning Records dated 03/14/25 provided by the ADON and the Corporate Regulatory Specialist revealed the facility did not have documentation on Ethics: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, ADON hired 03/03/25, LVN I hired 08/20/24, [NAME] D hired 10/15/24, LVN A re-hired 02/17/25, and Social Worker M.

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	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Arcos Del Norte Care Center	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)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 20026 Based on record reviews and interviews, the facility failed to maintain a training program to ensure staff were trained for 12 of 12 (Interim Administrator, Interim DON, Med Aide J, RN K, ADON, LVN I, Social Worker L, [NAME] D, LVN A, Maintenance, Social Worker M, and the Dietary Manager) reviewed for behavioral health training. The facility failed to ensure behavioral health training was provided to Interim Administrator, Interim DON, Med Aide J, RN K, ADON, LVN I, Social Worker L, [NAME] D, LVN A, Maintenance, Social Worker M, and the Dietary Manager. This failure could place residents at risk of not receiving care from incompetent/untrained staff. Findings included: Interview and record review on 03/13/25 at 3:40 PM, with HR/Payroll Coordinator revealed she was recently employed, and this was her first-time doing Personnel File Reviews with the state surveyor. She said she did not keep the training records for the staff in the personnel files and did not know who kept them. She called the ADON to her office and provided the ADON a copy of the list of staff selected to review training records. The ADON said she had just started working at the facility in March 2025, and did not know where the facility kept the training records for the staff. The ADON stated, I will go see what I can find and give you the requested information. Interview on 03/14/25 at 11:30 AM, the ADON stated she was still working on the training records and would provide them for review as soon as possible. In an interview on 03/14/25 at 2:30 PM, the Corporate Regulatory Specialist said she was not aware that the ADON still had not provided the training records for review that had been requested on 03/13/25 by the state surveyor. She said, A lot of the staff are new and might not know where the trainings records are kept. Let me follow up with the ADON, to see if she found the training records or if I need to call the corporate office to see if they have the training records. She said she was temporarily filling in for this facility and did not know where they kept the training records. In an interview on 03/14/25 at 3:10 PM, with the Corporate Regulatory Specialist revealed that the ADON had not been able to provide the state surveyor the training records that had been requested on 03/13/25. The Corporate Regulatory Specialist said, let me follow up on that. In an interview and record review on 03/14/25 at 5:07 PM, with the Corporate Regulatory Specialist informed the state surveyor that they had not found training records for the staff, and they had attempted to put together training records. They were not able to locate all the training records for those employees that had been selected for review of required trainings. Policies regarding required staff training were requested but were not received before exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the User Learning Records dated 03/14/25 provided by the ADON and the Corporate Regulatory Specialist revealed the facility did not have documentation for the following employees on behavior health training: Interim Administrator hired 01/31/25, Interim DON hired 02/03/25, Med Aide J hired 03/04/25, RN M hired 11/20/23, ADON hired 03/03/25, LVN I hired 08/20/24, Social Worker L hired 11/04/24, [NAME] D hired 10/15/24, LVN A re-hired 02/17/25, and Social Worker M hired 01/19/23 and Dietary Manager hired 12/06/21.