

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER St. Teresa Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10350 Montana Avenue El Paso, TX 79925	

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 0689</p> <p>Level of Harm - 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 observation, interview and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #10) of 10 residents reviewed for assistance with ADL's.</p> <p>CNA G failed to ask for assistance on 3/7/24 when providing perineal care to Resident #10, who required 2-person assistance, that resulted in fall with injury.</p> <p>This failure resulted in actual harm to Resident #10 on 03/07/24. It was determined to be past non-compliance due to the facility having implemented action that corrected it before the investigation began.</p> <p>This failure could place residents at risk of accidents and potential harm.</p> <p>Findings include:</p> <p>Record review of Resident #10's face sheet dated 4/24/24 revealed a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of muscle weakness and tracheostomy status.</p> <p>Record review of Resident #10's annual MDS assessment dated [DATE] revealed her cognitive status was severely impaired and was dependent on staff for toileting.</p> <p>Record review of Resident #10's care plan dated 4/1/24 revealed she required ADL assistance with 2-person assistance for incontinent care.</p> <p>Record review of Resident #10's kardex dated 4/24/24 revealed incontinent care requires 2 staff participation for incontinent care.</p> <p>Record review of Resident #10's progress note dated 3/7/24 written by LVN F revealed at approximately 1636 (4:36 pm) this nurse was called into room by CNA. [Resident #10] was on floor on her right side. CNA stated that during incontinent care resident started coughing and rolled off the side of the bed. Head to toe was performed on patient, laceration noted to right eyebrow 0.5 x 3.7 x 0.4 cm. Pressure was applied to site. Call placed to 911. EMS arrived at facility at approximately 1650 (4:50 pm). MD notified of fall. RP notified.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #10's progress note dated 3/7/24 written by ADON D revealed approximately 1636 (4:36 pm), made aware by CNA that during peri-care patient was being turned to her left-hand side when she started to cough and jerk. Patient rolled off her side of the bed and landed next to her bed on her right-hand side. CNA immediately called nurse. Patient was assessed while on the floor. Prom to x4 extremities with no verbal or non-verbal ques of pain. Pressure applied to right orbital laceration, 0.5 x 3.7 x 0.4 c to control bleeding .</p> <p>Record review of Resident #10's local hospital record dated 3/7/24 revealed patient is a [AGE] year-old female with previous stroke who was in bed with trach collar and PEG tube from nursing facility presenting to the emergency room after patient was dropped as they were transferring the patient, positive head strike, negative LOC, no blood thinner use. Patient at baseline is nonverbal, contracted in all extremities but does track with her eyes. This was a 3centimeter linear laceration. The laceration was above her right eyebrow. The wound was closed with 3-0 prolene in an interrupted fashion with 6 Suters. This was a single layer closure. The patient tolerated this procedure well and there were no complications. Patient is to follow up for suture removal or sooner for concerns of infection. Wound care instructions were given.</p> <p>During an interview on 4/24/24 at 3:05 pm, Resident #10's RP stated she had been notified of the fall on 3/7/24 and was advised Resident #10 was taken to the hospital for further evaluation. Resident #10's RP stated Resident #10 had not had a fall or similar incidents prior to the accident on 3/7/24.</p> <p>During an interview on 4/24/24 at 3:45 pm, LVN F stated he worked on 3/7/24 and was the charge nurse for Resident #10. LVN F stated he was called over to Resident #10's room by CNA G. LVN F stated when he entered Resident #10's room, he saw her on the floor on her right side. LVN F stated CNA G reported she was providing perineal care and when she was on her left side, Resident #10 coughed and leaned forward that resulted in her rolling off the bed. LVN F stated he conducted head to toe assessment and noticed laceration to her right eyebrow. LVN F stated he cleansed and applied pressure and the bleeding would not stop. LVN F stated he called 911 to have her admitted to hospital for further evaluation. LVN F stated Resident #10 required 2-person assistance for perineal care and was not sure why CNA G had not asked for assistance.</p> <p>During an interview on 4/24/24 at 3:55 pm, CNA G stated she worked on 3/7/24 and was the CNA assigned to Resident #10. CNA G stated she had provided perineal care to Resident #10 and had rolled her to her left side. CNA G stated when Resident #10 was on her left side, she coughed and leaned forward which caused her to roll over and fell on the floor. CNA G stated she called LVN F for assistance and to assess. CNA G stated she was familiar with Resident #10's care and knew she required 2-person assistance with incontinent care. CNA G stated she had access to Kardex and knew Resident #10 required 2-person assistance with incontinent care. CNA G stated she failed to ask for assistance because she felt it was easier for her to provide perineal care alone. CNA G stated her failure to ask for assistance resulted in a fall with injury to Resident #10. CNA G stated she was suspended and received in-service on checking Kardex before providing ADL care and asking for assistance to meet resident level of care requirement.</p> <p>During an interview on 4/25/24 at 3:22 pm, ADON H stated she was responsible for conducting random observations for all 3-shift staff on various ADL task to include bathing, bed mobility, incontinent care, and transferring. ADON H stated this monitoring was initiated post Resident #10 fall on 3/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering:</p> <p>QAPI- perform ADL task/ ADL dated 3/7/24 revealed: how to use Kardex; ensure you follow all care planned interventions including how much staff is required to perform an ADL; if unable to have proper number of staff to assist, do not perform the task until the proper amount of staff is present, do not rush; if for any reason the amount of staff assistance needed is not listed for bathing, bed mobility, transferring, walking, incontinent care, then you should contact the charge nurse, ADON, and or DON. Initiate the following for monitoring: asl 10 nursing staff members per week, how to locate how much assistance is needed for a resident task and what they would do if the proper amount of staff is not present. Document date/time staff members name, if they responded correctly, and any corrective action if needed.</p> <p>Reviewed monitoring tool utilized for bathing, bed mobility, transferring, incontinent care monitoring for the following dates: starting March 8, 2024- April 23, 2024. A total of 80 observations were completed with different ADL, covering all 3 shifts, various and CNAs. No concerns were identified.</p> <p>In-services dated 3/7/24:</p> <p>In-service on: while providing peri care on pts that are total dependent ensure 2 person aid at all times.</p> <p>In-service on: If unable to have the proper number of staff to assist a resident, do not perform task until the proper amount of staff is present. do not rush.</p> <p>In-service on: if more assistance is required than what is on Kardex, report to ADON, DON, or MDS case manager immediately so the Kardex can be adjusted.</p> <p>In-service on: Ensure that you follow all care planned interventions including how much staff is required to perform an ADL</p> <p>In-service on: If for any reason the amount of staff assistance needed is not listed for bathing, bed mobility, transferring, walking, incontinent care; then you should contact Charge nurse, ADON, DON.</p> <p>In-service on: how to use kardex.</p> <p>Observation of peri-care on 04/24/24 at 1:24 PM, revealed, nursing staff provided appropriate care. CNA A and CNA B both confirmed in-service training related to checking Kardex before care was provided and asking for help if needed CNA A and CNA B stated the facility was conducting random observations with ADL care. No concerns identified.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, record review the facility failed to ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain for 2 of 5 (Resident #9 and Resident #4) residents reviewed for urinary catheter.</p> <p>The facility failed to ensure Resident #9's urinary foley bag was placed below the bladder.</p> <p>The facility failed to provide catheter care for Resident #4 every shift.</p> <p>This failure could place residents with urinary catheters at risk of infection.</p> <p>Findings included:</p> <p>Resident #9</p> <p>Record review of Resident #9's face sheet dated 4/24/24 revealed a [AGE] year-old male who was readmitted on [DATE] with diagnoses of quadriplegia (one affected with partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), muscle wasting and atrophy, and anxiety.</p> <p>Record review of Resident #9's MDS assessment dated [DATE] revealed an intact cognition to be able to make daily decisions and recall information BIMS score of 15 and required 2-person assistance with bed mobility and toileting.</p> <p>Record review of Resident #9's care plan dated 4/1/24 revealed he had an ADL self-care deficit and needed 2-person assistance with toilet use.</p> <p>During an observation on 4/24/24 at 1:24 pm, Resident #9's urinary catheter was placed on top of the bed without a privacy bag. CNA A grabbed the urinary catheter with gloves and disposed it by waist level. CNA A opened the urinary catheter port and urine spilled on the floor. CNA A cleaned the urine off the floor with adult wipes, that do not have disinfectant agents.</p> <p>During an interview on 4/24/24 at 2:05 pm, CNA A stated she had received training regarding infection prevention during ADL care upon hire and annually. CNA A stated she should have emptied the urine below bladder to prevent urine backflow and urine spillage. CNA A stated by not emptying bag below bladder, she placed Resident #9 at risk for infection. CNA A stated she got nervous due to SO observing.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/24/24 at 2:40 pm, ADON D stated the CNAs received training regarding infection prevention during ADL care upon hire and annually during their competencies. ADON D stated CNAs were expected to empty urine from urinary catheter bag below bladder to prevent urine backflow and/or urine spillage. ADON D stated risks included cross contamination and acquired infection. ADON D stated nurses were responsible for ensuring the CNAs were emptying urine from urinary catheter bag during their daily rounds and nursing administration were responsible for ensuring competencies were good during their yearly evaluations.</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 04/24/24, revealed admission on 03/12/21 and re-admission on 04/10/24 to the facility. Resident #4 was a [AGE] year-old male diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection), Urinary Tract Infection, and mechanical complication of urinary catheter.</p> <p>Record review of Resident #4's quarterly MDS dated [DATE], revealed, no BIMS score was taken to evaluate the condition of Resident #4's ability to be able to recall and make daily decisions. Activities of daily living revealed total dependence on nursing staff for toileting. Had an indwelling catheter and was not incontinence of bladder. Diagnoses of Neurogenic Bladder (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem) and mechanical complications of catheter.</p> <p>Record review of Resident #4's care plan dated 03/21/24, revealed a Suprapubic catheter (placement of a drainage tube into the urinary bladder just above the pubic symphysis). Change the catheter as ordered. Position the catheter bag and tubing below the level of the bladder and in a privacy bag. Check tubing for kinks and maintain the drainage bag off the floor. Monitor/document for discomfort on urination and frequency.</p> <p>Record review of Resident #4's Administration Report dated 01/2024, 02/2024, 03/2024, 04/2024, revealed, provide catheter care every shift:</p> <p>01/2024 - there was no catheter care provided on 01/23/24, 01/26/24, 01/27/24, 01/31/24 for a shift.</p> <p>02/2024 - there was no catheter care provided on 02/16/24, 02/23/24, 02/28/24 for a shift.</p> <p>03/2024 - there was no catheter care provided on 03/07/24, 03/08/24, 03/14/24, 03/21/24, 03/26/24, 03/28/24 for a shift.</p> <p>04/2024 - there was no catheter care provided on 04/01/24, 04/03/24, 04/05/24, 04/06/24, 04/14/24, 04/15/24 for a shift.</p> <p>During an interview on 04/25/24 at 2:13 PM, with the DON, she stated if catheter care was to be provided on every shift, then it needs to be provided on every shift for Resident #4. The DON stated not providing catheter care on every shift as indicated could result in a risk for infection. The DON stated as per nursing if it was not documented it did not happen.</p> <p>Was not able to speak to Resident #4 as resident was out of the facility.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility Catheter Care policy dated 02/13/07, revealed, Review Residents' plan of care daily for changes.</p> <p>Keep drainage bag below level of bladder when cleaning the urethral area. keep drainage bag below level of bladder when cleaning the urethral area. The policy did not specify during the urine drainage.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on interview and record review, the facility failed to ensure medical records on each resident were complete and accurately documentd for 1 (Residents #7) of 2 residents reviewed for physician orders in that:</p> <p>There were no physician orders for Resident #7 who was Covid-19 positive on 01/31/24 and placed in isolation.</p> <p>This deficient practice could place Covid-19 positive residents at risk of decline in psychological mental health.</p> <p>Findings included:</p> <p>Record review of Resident #7's face sheet dated 04/25/24, revealed admission on 07/18/23 and re-admission on 01/11/24 to the facility.</p> <p>Record review of Resident #7's hospital history and physical dated 01/11/24, revealed, a [AGE] year-old female diagnosed with Chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>Record review of Resident #7's care plan dated 02/01/24, revealed, requiring isolation precautions specifically related to active Covid-19 infection. Please allow me to get some rest. Please encourage me to consume extra amounts of fluids daily. Please encourage me to cover my mouth and nose when coughing or sneezing. Please ensure I stay in my room, away from other people as much as possible. Please have oxygen available as ordered and whenever needed for shortness of breath. Please observe the effectiveness of my medication.</p> <p>Record review of Resident #7's order recap dated 01/11/24, revealed, Molnupiravir (an antiviral medicine that treats COVID-19) - Give 800 mg by mouth two times a day for Covid, until 02/01/24 at 11:59 PM.</p> <p>During an interview on 04/25/24 at 9:49 AM, with LVN C, he stated Resident #7 was Covid-19 positive. LVN C stated he called the physician and placed Resident #7 in isolation. LVN C stated Resident #7 did not need a physician order to be placed in isolation on 01/31/24.</p> <p>During an interview on 04/25/24 at 2:13 PM, with the DON, she stated a resident being placed into isolation needed to have a physician orders. The DON stated the purpose of physician orders was to see how the resident would receive treatment, care, and what the physician provides. the DON did not comment on what would be the negative outcome of not having physician orders.</p> <p>Record review on 04/25/24 at 3:08 PM, of a text message requesting a facility Physician Orders policy from the Administrator was not provided to state surveyor.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 (Resident #9) of 2 residents reviewed for perineal care and 1 (Resident #7) of 3 residents reviewed for infection control in that:</p> <p>Resident #7 was Covid-19 positive in January 2024, and the facility failed to record in the Infection Control Log for its Surveillance (a tool used to analysis data that can uncover an outbreak).</p> <p>CNA B failed to change gloves after cleaning Resident #9's BM and continued to provide ADL assistance with dirty gloves.</p> <p>These deficient practices could place residents at risk for infection due to improper care practices.</p> <p>Finding included:</p> <p>Resident #7</p> <p>Record review of Resident #7's face sheet dated 04/25/24, revealed admission on 07/18/23 and re-admission on 01/11/24 to the facility.</p> <p>Record review of Resident #7's hospital history and physical dated 01/11/24, revealed, a [AGE] year-old female diagnosed with Chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>Record review of Resident #7's care plan dated 02/01/24, revealed, requiring isolation precautions specifically related to active Covid-19 infection. Please allow me to get some rest. Please encourage me to consume extra amounts of fluids daily. Please encourage me to cover my mouth and nose when coughing or sneezing. Please ensure I stay in my room, away from other people as much as possible. Please have oxygen available as ordered and whenever needed for shortness of breath. Please observe the effectiveness of my medication.</p> <p>Record review of Resident #7's order recap dated 01/11/24, revealed, Molnupiravir (an antiviral medicine that treats COVID-19) - Give 800 mg by mouth two times a day for Covid, until 02/01/24 at 11:59 PM.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/25/24 at 1:55 PM, with the DON, she stated she was the Infection Preventionist and was responsible for the surveillance as part of infection control. The DON stated she started working with the facility in April 2024 and was not working at the facility when Resident #7 had acquired Covid-19 in January 2024. The DON stated the purpose of surveillance was to monitor outbreaks or infections. The DON stated the facility would not want to infection/disease to spread and the infection/disease might be reporter to the health department. The DON stated right now they did not have covid and anybody that turns out to be positive would need to be on the infection control log which was monitored by Surveillance.</p> <p>Record review of facility Infection Control Plan: Overview dated 03/2023, revealed, Infection Control - The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Maintains a record of incidents and corrective actions related to infections.</p> <p>Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection.</p> <p>Use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions.</p> <p>Record review of the facility Infection Log dated January 2024, revealed, Resident #7 was not documented for testing Covid-19 positive.</p> <p>Resident #9</p> <p>Record review of Resident #9's face sheet dated 4/24/24 revealed a [AGE] year-old male who was readmitted on [DATE] with diagnoses of quadriplegia (one affected with partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), muscle wasting and atrophy, and anxiety.</p> <p>Record review of Resident #9's MDS assessment dated [DATE] revealed a BIMS score of 15 and required 2-person assistance with bed mobility and toileting.</p> <p>Record review of Resident #9's care plan dated 4/1/24 revealed he had an ADL self-care deficit and needed 2-person assistance with toilet use.</p> <p>During an observation on 4/24/24 at 1:24 pm, CNA A and CNA B provided Resident #9 with assistance to change dirty brief. CNA B opened brief and wiped front area, Resident #9 was noted with catheter and no urine in brief. CNA A and CNA B explained reposition to clean his buttocks, he was noted with a small BM. CNA B cleaned the BM and removed dirty brief. CNA B placed new brief with dirty gloves (no BMM smear noted on dirty gloves) and continued to fix fitted sheets and applied lotion to residents' arms and face, and fixed residents trach tube with dirty gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/24/24 at 2:40 pm, CNA B stated she was supposed to change her gloves after she had cleaned Resident #9's BM, before she continued to put lotion on him and fixed his bed sheets and placed new clean brief. CNA B stated by not changing her gloves, she placed Resident #9 at risk for cross contamination that could result in risk of acquired infection. CNA B stated she received infection prevention and brief change training upon hire, annually and verbal reminders daily.</p> <p>During an interview at 2:40 pm, ADON D stated CNAs received training regarding infection prevention during ADL care upon hire and during annual competencies. ADON D stated when CNAs provide brief changes, they were expected to dispose dirty gloves when they dispose dirty brief. ADON D stated by not disposing dirty gloves and continued ADL care, the risk of infection was high due to BMs small particles, it was cross contamination. ADON D stated charge nurses were responsible for overseeing CNAs when conducting their daily rounds and nursing administration was responsible for conducting their annual competencies.</p> <p>Record review of the facility surveillance policy dated 2024, revealed, Essential elements of a surveillance system include use of standardized definitions and listings of symptoms of infections, use of surveillance tools such as infection control logs, walking rounds throughout the facility, identification of residents at risk for infection, identification of outcomes selected for surveillance, analysis of data that can uncover an outbreak, and feedback of results to the nursing staff so that they can assess the residents for signs of infection.</p> <p>Outcome surveillance - The outcome surveillance process consists of collecting/documenting data on individual cases and comparing the collected data to standard written definitions (criteria) of infections. The Infection Preventionist or other designated staff reviews data (including residents with fever or purulent drainage, and cultures or other diagnostic test results consistent with potential infections) to detect clusters and trends.</p> <p>The facility will track all infections or potential infections using the Infection Control Log.</p> <p>Record review of Bowel Incontinence Care policy dated 4/8/2005 read in part bowel incontinence management includes rehabilitation with rectal retraining, the application of external devices or collectors, maintenance of skin integrity, and preservation of self-esteem by preventing embarrassment and dependence. Perform fecal incontinence care: dispose of soiled briefs using universal precautions. The policy did not specify disposing of dirty gloves after changing dirty brief.</p>		