

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 06/07/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of needs for 1 (Resident #19) of 15 residents reviewed for call light button placement.</p> <p>-The facility failed to ensure that Residents #19 call light was within his reach.</p> <p>These failures could place residents at risk of not being able to have their needs met.</p> <p>Findings included:</p> <p>Review of Resident #19's Admission Record dated 06/05/2024, revealed a [AGE] year-old male, with initial admitted [DATE].</p> <p>Resident #19's diagnoses included: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), Tracheostomy status (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy status (surgical procedure used to insert a tube through the abdomen and into the stomach), and dependence of respirator status (need for mechanical ventilation).</p> <p>Review of Resident #19's quarterly MDS dated [DATE], revealed the resident was rarely/never understood. Section Functional Abilities and Goals revealed Resident #19 was dependent for oral hygiene, toileting hygiene, shower/bathe self, dressing, personal hygiene, and transfers.</p> <p>Review of Resident #19's comprehensive care plan dated 06/04/2024, revealed the resident was at risk for falls related to balance issues during transition. Part of the interventions included: Be sure the resident's call light is within reach and encourage the resident to use it. Another care area included Resident #19 had a communication problem related to no speech, rarely never understood. Part of the interventions included: Ensure/provide a safe environment: Call light in reach .</p> <p>During an observation on 06/04/2024 at 2:25 p.m., revealed Resident #19 lying in bed with the head of bed elevated. No distress was noted. The resident's push button call light was observed tangled under the wheels of a monitor and out of reach of the resident. Resident #19 was unable to provide any information regarding the call button.</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
---	-------	-----------

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 06/07/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 06/04/2024 at 2:28 p.m., CNA V entered Resident #19's room and said the resident needed to have the button within reach. CNA V said the button was tangled under the monitor and was out of reach of the resident. CNA V said the risk of not having the button in reach was the resident would be unable to contact staff and have their needs met.</p> <p>During an interview on 06/07/2024 at 1:32 p.m., ADON D said it was everyone's responsibility to ensure call lights are within reach of residents. ADON D said staff at the facility made intermittent rounds and check to make sure call lights are within reach. ADON said the risk was residents would not be able to ask for assistance. ADON said Resident #19 would be able to press the call button by placing the button within reach and in his hands. ADON said continuous training was being done with all staff to include ensuring that residents have call buttons in reach.</p> <p>During an interview on 06/07/2024 at 2:05 p.m., the DON said the purpose of a call light was to contact staff for assistance. The DON said the call button should be in reach of residents while in bed. The DON said all facility staff are responsible to ensure the call button is within resident reach. The DON said call buttons were monitored during daily rounding. The DON said the risk was residents not being able to call for assistance. The DON said trainings on call button access were completed upon hire and verbal reminders during rounds.</p> <p>During an interview on 06/07/2024 at 2:43 p.m., the Administrator said the purpose of call light was to bring attention to the resident for any care area. The Administrator said call light buttons are expected to be placed within reach of the residents. The Administrator said everyone was responsible for ensuring call lights are in reach during rounds. The Administrator said re-education was being provided. The Administrator said potential risk to residents was needs not being met .</p>

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 06/07/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on observation, interview, and record review the facility failed to ensure to ensure personal privacy during personal care for 1 of 10 (resident #22) whose care was reviewed in that:</p> <p>The facility failed to close the curtain when providing perineal care to Resident #22.</p> <p>This deficient practice could place residents at risk of dignity, low self-esteem and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #22's face sheet dated 06/07/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of vascular dementia (caused by the lack of blood that carries oxygen and nutrient to a part of the brain, it causes problems with reasoning, planning, judgment, and memory), cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced, this prevents brain tissue from getting oxygen and nutrients), and tracheostomy status (a surgical airway management procedure which consists of making an cut on the front of the neck and opening a direct airway through an incision in the trachea (windpipe)).</p> <p>Record review of Resident #22's quarterly MDS assessment dated [DATE] revealed her cognitive was severely impaired and was dependent of toileting.</p> <p>Record review of Resident #22's video footage dated 03/23/24 at 5:11 pm, revealed 2 CNAs providing perineal care with the curtain open and can see a shoulder of roommate sitting up on their bed.</p> <p>During an interview on 06/03/24 at 11:46 am, Resident #22's RP was at bedside and stated she had placed a video camera with audio in Resident #22 room. Resident #22's RP stated about 2 weeks ago she had seen 2 unidentified CNAs changing Resident #22's brief and the curtain was wide open, and the roommate was at bedside. Resident #22's RP said she had brought it up to the Weekend Supervisor as well as ADON D. Resident #22's RP stated she felt like Resident #22's privacy was violated, and Resident #22 had always been very private person.</p> <p>During an interview on 06/07/24 at 10:50 am, the Weekend Supervisor stated she was familiar with Resident #22. The Weekend Supervisor stated she had spoken to Resident #22's RP a while back and she had mentioned unidentified CNAs had left the curtain open while they had provided perineal care. The Weekend Supervisor stated she had educated the CNAs on the importance of privacy but did not remember who the CNAs were. The Weekend Supervisor stated she had reported voiced concern to ADON D. The Weekend Supervisor stated the CNAs had received training on providing privacy during any type of care provided upon hire and as needed. The Weekend Supervisor stated the nurses were responsible of ensuring all residents received privacy during all care provided. The Weekend Supervisor stated failure to pull the curtain while perineal care was provided was a violation of her privacy and a dignity concern.</p> <p>(continued on next page)</p>		

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 06/07/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/07/24 at 1:32 pm, ADON D stated CNAs received training on providing privacy during any care provided upon hire, quarterly and during their annual proficiencies. ADON D stated the nurses were responsible of ensuring the CNAs were providing privacy during care while they conducted their rounds at least every 2 hours. ADON D stated he was aware of the incident and had coached the CNAs (he could not remember who they were) on the importance on pulling the curtain when providing care when there was a roommate in the room. ADON D stated failure to close curtain when providing perineal care while roommate was in the room was a risk for privacy not being respected and a dignity concern.</p> <p>During an interview on 06/07/24 at 2:43 pm. the Administrator stated all CNAs received training regarding providing privacy during perineal care upon hire and as needed. The Administrator stated it was his expectation for the curtain to be pulled when perineal care was provided to any resident specially when a room is shared. The Administrator stated the risk for not closing the curtain was no privacy was provided to Resident #22.</p> <p>Record review of the Resident Rights policy dated 11/28/16 reflected in part, The resident has the right to exercise as a resident of the facility and as a citizen or resident of the United States. Privacy and confidentiality- The resident has a right to personal privacy .</p>

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 06/07/2024
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on observation, interview, and record review the facility failed to ensure the prompt resolution of all grievances to include ensuring that all written grievances decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent finding or conclusions regarding the resident's concerns; a statement as to whether the grievance was confirmed, any corrective action or to be taken by the facility as a result of the grievance, and the date when the decision was issued for 1 of 10 (resident #22) reviewed for resident rights.</p> <p>The facility failed to initiate and complete a grievance for Resident #22's family who voiced concern of unidentified CNAs not closing the curtain when providing perineal care.</p> <p>This failure could place residents at risk for grievances not being addressed or resolved promptly.</p> <p>Findings included:</p> <p>Record review of Resident #22's face sheet dated 06/07/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of vascular dementia (caused by the lack of blood that carries oxygen and nutrient to a part of the brain, it causes problems with reasoning, planning, judgment, and memory), cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced, this prevents brain tissue from getting oxygen and nutrients), and tracheostomy status (a surgical airway management procedure which consists of making an cut on the front of the neck and opening a direct airway through an incision in the trachea (windpipe)).</p> <p>Record review of Resident #22's quarterly MDS assessment dated [DATE] revealed her cognitive was severely impaired and was dependent of toileting.</p> <p>Record review of Resident #22's video footage dated 03/23/24 at 5:11 pm, revealed 2 CNAs providing perineal care with the curtain open and can see a shoulder of roommate sitting up on their bed.</p> <p>During an interview on 06/03/24 at 11:46 am, Resident #22's RP was at bedside and stated she had placed a video camera with audio in Resident #22 room. Resident #22's RP stated about 2 weeks ago she had seen 2 unidentified CNAs changing Resident #22's brief and the curtain was wide open, and the roommate was at bedside. Resident #22's RP said she had brought it up to the Weekend Supervisor as well as ADON D. Resident #22's RP stated she felt like Resident #22's privacy was violated, and Resident #22 had always been very private person.</p> <p>Record review of the grievances for March 2024, April 2024, May 2024 and June 2024 revealed no grievance found for Resident #22's RP voiced concern regarding not closing curtain for privacy during perineal care.</p> <p>(continued on next page)</p>		

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 06/07/2024
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/07/24 at 10:50 am, the Weekend Supervisor stated she was familiar with Resident #22. The Weekend Supervisor stated she had spoken to Resident #22's RP a while back and she had mentioned unidentified CNAs had left the curtain open while they had provided perineal care. The Weekend Supervisor stated she had educated the CNAs on importance of privacy but did not remember who the CNAs were. the Weekend Supervisor stated she had reported to voiced concern to ADON D. The Weekend Supervisor stated she did not initiate a grievance, she stated she followed chain of command and reported to ADON D who was responsible for Resident #22.</p> <p>During an interview on 06/07/24 at 1:32 pm, ADON D stated CNAs received training on providing privacy during any care provided upon hire, quarterly and during their annual proficiencies. ADON D stated he had been notified by Resident #22's RP regarding her concern of CNAs not closing curtain when they were providing perineal care. ADON D stated he had educated the CNAs (who he could not recall who they were) verbally regarding the importance of providing privacy during perineal care. ADON D stated he did not initiate a grievance due to the issue being resolved right then and there.</p> <p>During an interview on 06/07/24 at 2:43 pm. the Administrator stated all CNAs received training regarding providing privacy during perineal care upon hire and as needed. The Administrator stated it was his expectation for a grievance to have been initiated so they could monitor the response from family's concerns and an in-service would had been initiated for all staff regarding providing privacy when providing perineal care. The Administrator stated risk for not completing a grievance was no paper trail for monitor the satisfaction of facility's response, no in-service was initiated, and no documentation to show the concern was addressed.</p> <p>Record review of the Grievance policy dated 11/02/2016 reflected in part The resident has the right to voice grievance to the facility or the other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the residents may have. 5- all grievances involving alleged violations of neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist.</p>		

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 06/07/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>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 (Residents #19 and #20) of 7 residents reviewed for assistance with ADLs.</p> <p>-The facility failed to ensure Residents #19 and #20, who required assistance with ADLs, did not have long fingernails.</p> <p>These failures could affect residents who were dependent on assistance with ADLs and could result in poor care, lack of dignity, and skin tears due to long nails.</p> <p>Findings include:</p> <p>Resident #19:</p> <p>Review of Resident #19's Admission Record dated 06/05/2024, revealed a [AGE] year-old male, with initial admitted [DATE]. Resident #19's diagnoses included: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), Tracheostomy status (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy status (surgical procedure used to insert a tube through the abdomen and into the stomach), and dependence of respirator status (need for mechanical ventilation).</p> <p>Review of Resident #19's quarterly MDS dated [DATE], revealed resident is rarely/never understood. Section Functional Abilities and Goals revealed Resident #19 was dependent for oral hygiene, toileting hygiene, shower/bathe self, dressing, personal hygiene, and transfers.</p> <p>Review of Resident #19's comprehensive care plan dated 06/04/2024, revealed Resident #19 had an ADL self-care performance deficient. Part of the inventions included: Personal hygiene: the resident requires total assistance with personal hygiene care.</p> <p>During observation on 06/03/2024 at 12:11 p.m., revealed Resident #19 was lying in bed. The resident's fingernails appeared long and jagged with some dark discoloration underneath. Resident #19 did not offer a response when asked about his fingernails.</p> <p>During interview on 06/03/2024 at 12:14 p.m., LVN I entered Resident #19's room and said that staff members, CNAs or nurses conducted grooming of fingernails for Resident #19. LVN I looked at Resident #19's fingernails and said the nails were long. LVN I said she did not know when was the last time his nails were trimmed or filed. LVN I said CNAs assisted resident with bathing and part of the bathing included checking on nails. LVN I said she did not know when was the last time the resident was bathed. LVN I said she did not usually work on Resident #19's hall.</p> <p>Resident #20:</p> <p>(continued on next page)</p>		

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 06/07/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #20's Admission Record dated 06/06/2024, revealed a [AGE] year-old male, with initial admitted [DATE]. Resident #20's diagnoses included: Tracheostomy status (an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy status (surgical procedure used to insert a tube through the abdomen and into the stomach), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Review of Resident #20's quarterly MDS dated [DATE], revealed a BIMS score of 14 indicating the resident was cognitively intact. Section Functional Abilities and Goals revealed Resident #20 required max assistance with bathing and personal hygiene.</p> <p>Review of Resident #20's comprehensive care plan dated 06/06/2024, revealed Resident #20 had an ADL self-care performance deficient. Part of the interventions included: Personal hygiene: the resident requires x 1 staff participation with personal hygiene.</p> <p>During observation and interview on 06/04/2024 at 2:38 p.m., revealed Resident #20 was lying in bed. Resident #20's fingernails appeared long and jagged. Resident #20 was asked yes/no questions and resident indicated he did not know when the last time his nails were cut. Resident #20 communicated that he did not like his nails long. Resident #20 communicated that facility staff should had been cutting his nails. Resident #20 did not know why his nails had not been cut.</p> <p>During an interview on 06/07/2024 at 1:32 p.m., ADON D said fingernail care was done when residents are showered/bathed. The ADON D said Residents #19 and #20 do not have history of refusing behaviors. ADON D said the CNA in charge of the patient should cut the nails. ADON D said nails carry a lot of bacteria. ADON D said residents could also scratch themselves with long, jagged nails.</p> <p>During an interview on 06/07/2024 at 2:05 p.m., the DON said CNAs and nurses were responsible for trimming fingernails. The DON said this can be done when a staff member sees someone who has long nails during shower days. The DON said she and the ADONs are supposed to oversee that the tasks were done including trimming and cutting of nails. The DON said the risk for having long nails was bacteria could get under the fingernails.</p> <p>During an interview on 06/07/2024 at 2:43 p.m., the Administrator said nursing were responsible for trimming nails. The Administrator said there was no time frame on when nail care was performed. The Administrator said CNAs should have brought it to the attention of nursing for trimming.</p> <p>Record review of facility policy titled Nail Care dated 2003, reflected in part Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails . Goals: Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions.</p>		

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 06/07/2024
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</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 #21) of 9 residents reviewed for care ADLs.</p> <p>-The facility failed to follow the comprehensive person-centered care plan for ADL self-care performance deficit requiring two-person participation for bathing.</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services as indicated in their comprehensive person-centered plans developed to address their needs, accidents and potential harm.</p> <p>Findings include:</p> <p>Review of Resident #21's Admission Record dated 06/06/2024, revealed at [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #21's diagnoses included the following: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and moderate intellectual disability (condition that limits intelligence and disrupts abilities necessary for living independently).</p> <p>Review of Resident #21's MDS dated [DATE], revealed the resident was rarely/never understood. Functional Abilities and Goals revealed that Resident #21 was dependent on staff for shower/bathing.</p> <p>Review of Resident #21's comprehensive care plan dated 06/06/2024, revealed Resident #21 had an ADL Self Care Performance Deficit. Part of the interventions included: Bathing: requires staff x2 for assistance.</p> <p>During an observation and interview on 06/04/2024 at 3:21 p.m., CNA-T was observed pulling a shower gurney with Resident #21 into shower room. Resident #21 was covered with a sheet. CNA-T said he was going to shower Resident #21. No other staff were noted in the shower room. The Investigator remained in the open area in position to see the shower room door. CNA-T remained in the shower room until 3:35 p.m., at which time he brought Resident #21 out of shower room covered with white sheet on her body and towel on her head and went to her bedroom.</p> <p>During an interview on 06/04/2024 at 3:45 p.m., Resident #21 did not provide any response to any questions asked regarding bathing.</p> <p>(continued on next page)</p>		

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 06/07/2024
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/04/2024 at 6:30 p.m., CNA-T said there were no incidents when he bathed Resident #21. CNA-T said he bathed Resident #21 alone because there was pressure to get showers done. CNA-T said he bathed Resident #21 mostly alone, but the ADON had helped. The Investigator informed CNA-T that he sat outside of door and did not see the ADON go in. CNA-T said Resident #21 required bathing assistance of two-staff persons. CNA-T said he bathed Resident #21 by himself and at times had to because of the pressure of getting all the showers done. CNA-T said he acted alone, and no one instructed him to shower Resident #21 by himself. CNA-T said although nothing happened to the resident, there was a risk the resident could be injured during bathing with one person or not bathed thoroughly.</p> <p>During an interview on 06/07/2024 at 1:32 p.m., ADON D said he was familiar with Resident #21. The ADON D said the care plan should be followed because of a safety issue for both patient and employee. The ADON D said staff were not allowed to modify the care plan. The ADON D said CNAs had access to the tasks which includes type of assistance needed. The ADON D said Resident #21 requires two-person assist while bathing.</p> <p>During an interview on 06/07/2024 at 2:05 p.m., the DON said the purpose of a care plan had to do with everything a patient needs for care. The DON said expectation for bathing x 2, means staff need 2 persons to assist. The DON said all CNAs had access to the Kardek (tool used by CNAs to reference to identify care needed for each resident) with information regarding type of assistance needed. The DON said staff are trained upon hired and continuously reminded to refer to Kardek when assisting residents. The DON said the risk of failing to follow the care plan was injury to the resident.</p> <p>During an interview on 06/07/2024 at 2:43 p.m., the Administrator said all CNAs had access to kiosk that references levels of type of assistance needed. The Administrator said the expectation was two persons assist resident with bathing if that is what is care planned. The Administrator said nursing managers, the DON, and ADONs oversee that care plans are implemented correctly. The Administrator said the risk of not following the care plan was the resident was not proper care was not provided that could result in injury. The Administrator said staff are continuously trained on following care plans.</p> <p>Review of facility provided Bath, Tub/Shower policy dated 2003, under Procedure reflected in part Become familiar with type and pattern of bathing, assistance or aids needed .</p> <p>Review of facility-provided Comprehensive Care Planning policy dated March of 2018, reflected in part The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. The services provided or arranged by the facility, as outlined by the comprehensive care plan, will meet professional standards of quality. The facility will ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity.</p>		

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 06/07/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 of 10 (resident #22) reviewed for oxygen therapy.</p> <p>The facility failed to replace Resident #22 tracheostomy ventilation circuit tubing that was seen with red/brownish particles for 2 days.</p> <p>This failure could place residents on oxygen therapy at risk of cross contamination resulting in acquired infection.</p> <p>Findings included:</p> <p>Record review of Resident #22's face sheet dated 06/07/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of vascular dementia (caused by the lack of blood that carries oxygen and nutrient to a part of the brain, it causes problems with reasoning, planning, judgment, and memory), cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced, this prevents brain tissue from getting oxygen and nutrients), and tracheostomy status (a surgical airway management procedure which consists of making an cut on the front of the neck and opening a direct airway through an incision in the trachea (windpipe)).</p> <p>Record review of Resident #22's quarterly MDS assessment dated [DATE] revealed her cognitive was severely impaired and she had had tracheostomy .</p> <p>During an observation on 06/03/24 at 11:46 am, revealed Resident #22 was in bed, head of bed elevated and the tracheotomy ventilation circuit tubing was noted to have red/brownish particles noted inside approximately 2 inches long. Resident #22 was not verbal and there were no signs of distress noted.</p> <p>During an observation on 06/04/24 at 9:27 am, revealed Resident #22 was in bed, head of bed elevated and the tracheotomy ventilation circuit tubing was noted to have red/brownish particles noted inside approximately 2 inches long. Resident #22 was not verbal and there were no signs of distress noted.</p> <p>During an observation and interview on 06/07/24 at 9:29 am, RT W stated he was the charge RT for Resident #22 today and had worked with her the day before as well (06/03/24).The RT stated the respiratory department was responsible of replacing all oxygen/tracheostomy equipment and it was completed once a week. The RT stated there was some dry particles located in the ventilation circuit tube and had not noticed it the day before. The RT stated there was no risk to Resident #22 for having the dry particles inside the ventilation circuit tube.</p> <p>(continued on next page)</p>		

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 06/07/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/07/24 at 2:05 pm, the DON stated the nursing department was responsible for ensuring the tracheotomy equipment was always kept clean and changed once a week or as needed. The DON stated the RTs should be checking equipment daily when they provide any type of respiratory care. The DON stated it was expected for the RTs to change equipment as needed if any dry particles were noted inside any of the tubing that was connected to the resident's tracheostomy. The DON stated failure to replace the ventilation circuit tube that had dry particles inside the tube placed Resident #22 at risk of infection .</p>