| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676342 | A. Building<br>B. Wing | 01/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St. Teresa Nursing & Rehab Center | 10350 Montana Avenue<br>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) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998<br><br>Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were complete and accurately documented for 1 of 4 residents (Resident #3) reviewed for medical records.<br><br>The facility failed to ensure Resident #3's inventory record accurately documented items for the resident during her stay at the facility.<br><br>This failure could place residents at risk of lost, missing or stolen items.<br><br>Findings include:<br><br>Record review of Resident #3's face sheet, dated 01/06/24, revealed admission on 02/02/23, re-admission on 08/08/23 and most recent re-admission on 02/18/24 to the facility.<br><br>Record review of Resident #3's history and physical, dated 04/12/24, revealed an [AGE] year-old female with a diagnosis which included Dementia (neurological conditions that cause a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life).<br><br>Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 8, which indicated severely impaired cognition. Resident #3 was able to recall or make daily decisions.<br><br>Record review of Resident #3's Care Plan, reviewed on 08/08/23, revealed impaired cognitive function or impaired thought. Administrator meds as ordered.<br><br>Record review of Resident #3's Inventory Sheet, dated 02/10/23, revealed clothing/shoes/outer wear/ furniture/other items to be coded as Not Applicable. For jewelry, watches, etc. (used to avoid giving a complete list) was coded for Nothing of Significant Value.<br><br>Record review of Resident #3's Grievances for 10/21/24 and 12/20/24, revealed no documentation regarding a lost, missing, and or stolen blanket.<br><br>(continued on next page) |

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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676342 | A. Building<br>B. Wing | 01/06/2025 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/02/24 at 2:19 PM with the DON, he stated he received a grievance from Family Member B which indicated she bought a Christmas blanket to Resident #3. The DON stated the next day Family Member B mentioned the blanket was stolen. The DON stated the blanket appeared to be a little off but looked the same before when it was bought too Resident #3. The DON stated the Administrator replaced the blanket. The DON stated during admission a residents items needed to be immediately inventoried.<br><br>During an interview on 01/06/25 at 1:56 PM with Medical Records/Central Supply, she stated residents coming into the facility had to have their items inventoried by either the receptionist, Admission Coordinator, or the Guest Relations personnel. Medical Records/Central Supply stated once those different department inventory the residents' items then they had to submit it to her so she could enter it into PCC. Medical Records/Central Supply stated the family or visitor who brought in items for the residents needed to declare it to the receptionist or the nurses so it could be inventoried and submitted to her to put into the residents' chart. Medical Records/Central Supply stated there would be no negative outcome if the residents' items were not inventoried.<br><br>During an interview on 01/06/25 at 2:19 PM, with the Admission Coordinator, she stated residents coming into the facility needed to have their personal belonging inventoried, so the facility knew what they came with and what they had during their stay at the facility. The Admission Coordinator stated anybody could inventory the items of a resident. The Admission Coordinator stated she had only seen three inventory sheets dating: 02/03/23, 08/10/23 (the document was incomplete and not signed off on) and 02/20/24. The Admission Coordinator stated the 08/10/23 inventory sheet needed to be complete for accuracy and completion. The Admission Coordinator stated the negative outcome of not completing the inventory sheet or not inventory the item would be something getting lost or there was no record of it.<br><br>During an interview on 01/06/24 at 3:58 PM with the DON, he stated resident items needed to be documented and inventoried. The DON stated the negative outcome would be that it did not happen, and someone could say someone stole something from them. The DON stated even if family or visitors brought items in and didn't report it and staff saw it, they had to inventory it.<br><br>Record review of the facility's, undated, Resident Inventory Policy revealed, Items of sentimental value DO need to be documented. After completing the inventory, upload it and file the original copy in the resident thin record. *** If a resident acquires items after the initial completion of the inventory list, the new items must be added to the inventory list. **<br><br>Record review of the facility's Official Letter signed off by Family Member B, dated 12/11/24, revealed, This document was to confirm that the facility [facility name] was reimbursing Family Member B resident representative Thirty Dollars in cash for a blanket. |