

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 02/06/2025
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</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 residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #1) of 6 residents reviewed for gastrostomy tube management quality of care.</p> <p>-The facility failed to ensure Residents #1 was provided with the correct feeding through gastrostomy tube (g-tube, feeding tube) as ordered.</p> <p>This failure could place residents who received feedings by gastrostomy tube at risk for weight gain and decline in health.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record dated 02/03/2025, revealed a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident # 1's History and Physical dated 01/15/2025, revealed diagnoses of nutritional deficiency, unspecified (lack of essential nutrients in the body without specifying which particular nutrient is deficient), and unspecified protein-calorie malnutrition (disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food).</p> <p>Record review of Resident # 1's Admission Nurse Note dated 01/15/2025, revealed resident admission weight was 146.2 lbs. Section J (Oral/Nutrition) revealed resident received nutrition via G-tube enteral tube. Formula and rate read vital at 65 cc/hr.</p> <p>Record review of Resident #1's Order Summary Report dated 02/03/2025, revealed an order with start time of 01/26/2025 for Enteral Feed Order every shift Isosource 1.5 at 50ml/hr.</p> <p>During an observation and interview on 02/03/2025 at 10:23 a.m., Resident #1 said she received all her nutrition via tube feeding and cannot eat anything by mouth. Resident #1 said she had not had any issues with the tube feeding. The feeding pump was administering Isosource 1.5 tube feeding, set at continuous rate of 65 ml/hr.</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/03/2025 at 1:55 p.m., the DON said the purpose of orders were for the betterment of the patient care and treatment. The DON said there could be a risk of harm if an order was not followed. The DON said the risk to the patient of failing to follow the correct feed order could affect weight gain. The DON said the person responsible to ensure orders were followed, were nursing staff and nursing management. The DON said that he was responsible to ensure orders are followed by nursing staff through audits. The DON said he had a discussion with the Dietician and the Dietician sent him an order converting Resident #1's feeding from Peptamen at 65 ml/hr. to Isosource at 50 ml/hr. The DON said he had communicated the feeding order change to a nurse from the other side of the building and asked her to physically walk over to the other side of the building to check if staff understood the changes to the enteral feeding order. The DON said the breakdown occurred when he did not follow-up to ensure the instructions were carried out.</p> <p>During an interview on 02/05/2025 at 4:19 p.m., the Dietician said when Resident #1 was readmitted to the facility from the hospital on 01/15/2025, she came in with an order for Peptamen 1.5 at 65 ml/hr. The Dietician said when she saw Resident #1 on 01/23/2025, she changed the order to Isosource 1.5 and decreased the rate to 50 ml/hr. The Dietician said Peptamen was a highly specialized formula that the hospitals seem to use with their patients. The Dietician said she had been watching Resident #1 carefully and had a concern about her taking in too many calories and possible weight gain. The Dietician said the biggest risk to Resident #1 not following the order was weight gain. The Dietician said Resident #1 was tolerating the feeding just fine.</p> <p>Record review of Resident #1's weight records revealed resident went from admission weight of 146.2 on 1/15/2025 to 148.0 on 02/06/2025.</p> <p>During an interview on 02/06/2025 at 10:14 a.m., the PCP said the issue with the feeding order not being followed from 01/24/2025 to 02/03/2025 was not a risk to health of Resident #1. There was no risk of aspiration or any other issues.</p> <p>During an interview on 02/06/2025 at 1:25 p.m., the Administrator said the purpose of orders were to follow the plan of care for resident treatment. The Administrator said the risk of failing to follow feeding tube orders could be the resident could fail to get proper nutrition. The Administrator said nursing management and charge nurses were responsible to ensure orders were followed.</p> <p>Record review of facility policy titled Enteral Nutrition dated 02/13/2007, reflected in part the facility will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth. The Nursing Services Department is responsible for all feeding equipment and the administration of tube feedings. Problems with the administration of the tube feeding are monitored and corrected by nursing.</p>		