STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676342	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Teresa Nursing & Rehab Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the right to be free from abuse was provided for 2 (Resident #1 and Resident #2) of 8 residents reviewed for abuse, in that: The facility failed to protect Resident #1 from abuse on 3/20/25 when Resident #1 hit Resident #2 on the face. As a result, there was bruising immediately starting to form on Resident #1's right side of face close to the right [NAME], bruising notes to right hand on knuckles, and bruise noted to right shin. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 03/20/2025 and ended on 03/25/2025. The facility had corrected the noncompliance before the investigation began. These failures could place residents at risk of abuse, injury, intimidation, fear, agitation, and psychological harm. Findings included: Resident #1: Record review of Resident #1's admission Record dated 05/15/2025, revealed the resident was a [AGE] year-old female with an original admission date of 02/21/2024. Resident #1's diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), anxiety disorder (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), and impulse disorder (mental health condition that makes it difficult to control actions or reactions). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 99 indicating that the resident was unable to complete the interview. Resident #1 with short-term and long-term memory problems. Section E - Behavior revealed Resident #1 did not exhibit any physical, or verbal symptoms directed toward others. Section GG - revealed Resident #1 uses a manual wheelchair and able to wheel herself independently. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 04/28/2025, reflected Focus (initiated 03/21/2025): Resident #1 had a behavior problem related to alert/oriented of zero; needs redirection enters other resident rooms. Goal: Resident will have fewer episodes. Interventions: administer medications as ordered; anticipate and meet resident's needs; care givers to provide opportunity for positive interaction, attention; intervene as necessary to protect the rights and safety of others; minimize potential for resident's disruptive behaviors; monitor behavior episodes and attempt to determine underlying cause; praise any indication of resident's progress/improvement in behavior; and provide a program of activities that is of interest and accommodates residents status. Resident #2: Record review of Resident #2's admission Record dated 05/15/2025, revealed the resident was an [AGE] year-old male with an admission date of 08/26/2022. Resident #2's diagnoses included vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 02 indicating severe cognitive impairment. Section E - Behaviors reflected Resident #2 did not exhibit any physical or verbal behaviors towards others. Record review of Resident #2's care plan, dated 04/18/2025, reflected Focus (initiated 03/21/2025): Resident #2 had potential to demonstrate verbally and physical abusive behaviors, aggressive towards other residents. Goal: Resident #2 will demonstrate effective coping skills. Interventions: assess and anticipate resident's needs; assess resident's coping skills and support system; assess resident's understanding of the situation; notify the charge nurse of any abusive behaviors. Record review of the Provider Investigation Report dated 03/25/25 reflected, facility staff CMA F heard Resident #2 say to get out of his room. CMA F heard and walked into the room where she discovered Resident #2's belongings that were on his bedside table were thrown. Resident #1 was at edge/bottom of bed (not in arms reach of Resident #1). CMA F immediate removed Resident #2 from the room. CMA F informed charge nurse. Resident assessed for safety. Administrator, DON and Medical Director notified. Abuse neglect policy initiated. Record review of a witness statement from CMA F dated 03/20/2025, reflected CMA F found Resident #1 in Resident #2's room in her wheelchair with her back turned away from the door and next to Resident #2's bed. There was water all over the floor with the water pitcher, the sandals of (Resident #2), and a fork on the floor. Resident #1 told CMA F that Resident #2 had hit her. CMA F took Resident #1 out of the bedroom and reported the incident to LVN C. Interview on 05/15/2025 at 2:23 p.m., Resident #1 stated she did not recall any incidents involving any other residents. Resident #1 said she did not remember any incidents of going to another resident's bedroom and being hit with anything. Resident #1 said she felt safe at the facility and was not afraid of anyone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/15/2025 at 2:51 p.m., Resident #2 stated he did not remember any incident involving another female resident coming into his bedroom. Resident #2 said he did not remember any incident where he had to tell another resident to get out of his room, or any incident where he threw anything hitting the other resident. Resident #2 stated he did not have any issues with any other residents at the facility. Resident #2 stated he felt very safe at the facility. Interview on 05/15/2025 at 4:32 p.m., CMA F stated on the afternoon of 03/20/2025, she was passing out medications to other residents in the hall and heard someone yelling out. CMA F said started walked into the hall and turned into Resident #2's bedroom and saw Resident #1 seated on her wheelchair inside the room at the foot end of Resident #2's bed. CMA F stated she saw Resident #2's shoes next to Resident #1 on the floor and water bottle tipped over with spilled water. CMA F said she did not see Resident #2 hit Resident #1. CMA F said Resident #1 told her that Resident #2 had hit her. CMA F said she assisted Resident #2 out of the room on her wheelchair. CMA F said she reported it to LVN C. CMA F said Resident #1 self-propels and had history of wandering around the facility. CMA F said there had been no prior incidents between the Resident #1 and Resident #2 before 03/20/2025 nor any incidents since. Interview on 05/16/2025 at 8:38 AM, the DON revealed LVN C was no longer working a regular schedule at the facility and moved to a PRN role. On 05/16/2025 at 9:16 a.m., surveyor called LVN C with no answer. Voicemail message with call back information was left. On 05/16/2025 at 9:34 a.m., surveyor asked DON to assist in contacting LVN C. Call back information provided to DON. DON called and left voicemail message. DON texted contact information to LVN C. On 05/16/2025 at 10:25 a.m., surveyor called LVN C with no answer. Voicemail message with call back information was left. Record review of Resident #1's progress notes dated 03/20/2025 and written by LVN C, reads At around 1800 (6:00 p.m.) Resident #2 was heard by CMA F yelling from a room. Resident #1 was found in Resident #2's room. CMA F witnessed Resident #2 sitting up in bed hitting Resident #1 in face and throwing water pitcher and shoes at her telling her to go away. CMA F then removed Resident #1 from the room and notified LVN C about the incident. LVN C initiated head to toe assessment where bruising immediately started forming to Resident #1's right side of face close to right eye, bruising noted to right hand on knuckles and bruise noted to right shin. Resident #1 was not complaining of any pain. LVN C applied ice to help with swelling resident cooperating well. LVN C called Resident #1 family member (FM) to notify about incident. RM verbally understood and asked to be called and notified of any changes. DON, MD and Administrator notified. Record review of Resident #2's Event Nurses' Note - Behavior, dated 03/20/2025, completed by LVN C, reads LVN C was notified that resident was noted hitting and throwing things to another resident that was wandering in his room. CMA F was able to remove other resident from room but did witness resident throwing things to other resident. Resident #2 said that lady came into my room and started grabbing my stuff. Physician and RP notified. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/16/2025 at 11:20 a.m., Administrator said Resident #2 had never had any altercation with any other residents prior to the incident reported on 03/20/2025. The Administrator said CMA F witnessed the incident and reported the incident. The Administrator said that Resident #1 has dementia and had history of wandering around the facility and had to be redirected from entering other resident's rooms in the past. The Administrator said on the day of the incident, Resident #1 wandered into Resident #2 room and Resident #2 threw items off the bedside table and hit Resident #1 on the face. The Administrator said there had been no other incidents between these two prior to 03/20/2025 or since the incident. The Administrator said Resident #2 had not exhibited any physical aggression towards any other resident before. The Administrator said Resident #1 was assessed for injury and he immediately initiated an investigation, verified Resident #2 was not exhibiting any further aggression and placed Resident #1 on one-to-one supervision for initiating the incident. The Administrator said Trauma Informed PRN Assessments were completed for Resident #1 and Resident #2. Record review of facility Abuse/Neglect policy, revised 09/09/24, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Resident to Resident - The above policy will apply to potential resident-to-resident abuse. Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: Record review of Resident #1's Trauma Informed PRN Assessment completed 03/25/2025 with no concerns. Record review of Resident #2's Trauma Informed PRN Assessment completed 03/21/2025 with no concerns. Review of Resident #1's care plan updated on 03/21/2025, revealed focus on resident wandering in other resident's rooms, which included interventions of monitoring, record, and report to MD new onset signs and symptoms of delirium, changes in behavior, altered mental status, communication decline, disorientation, lethargy, restlessness and agitation. Reorient the resident to person, place, time, situation as required. Review of Resident #2's care plan updated on 04/01/2025, revealed focus: the resident had a behavior problem related to hitting and throwing things to another resident. Goal: The resident will have no evidence of behavior problems. Interventions: administer medications as ordered; anticipate and meet the resident's needs; intervene as necessary to protect the rights and safety of others; minimize potential for resident's disruptive behaviors; praise any indication of resident's progress/improvement in behavior; provide a program or activities that is of interest and accommodates resident's status. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Safe surveys were completed with 8 residents with no issues noted. Record review of facility In Service Training dated 03/20/25, provided by Administrator reflected staff were In Serviced on the Abuse and Neglect to include responding to resident-to-resident incidents. Interviews on 05/15/2025 from 2:26 p.m. to 4:32 p.m., with ADON B, CNA D, CNA E, CMA F, HR, DON, and LVN I revealed the facility staff were able to verify education was provided to them. The staff stated they were educated on different types of abuse/neglect and responding to resident-to-resident incidents. Staff revealed they would report these and other signs to the Abuse Coordinator, the Administrator, immediately if they witness or suspected any issues with resident-to-resident abuse.