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	12/19/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the discharge needs of each resident are identified and the discharge planning process results in the development of a discharge plan for each resident for 1 (Resident #1) of 4 residents reviewed for discharge planning. The facility failed to develop a discharge plan when Resident #1 was issued a 30-Day Discharge Notice on 11/26/25 due to non-payment. This failure could result in residents experiencing psychosocial harm due to inappropriate discharges and placed residents at risk of being discharged without alternate placement and not having access to available advocacy services, discharge/transfer options, and denying them their rights in the appeal process. Findings included:Record review of Resident #1's admission Record revealed Original admission Date 05/28/25 and re-admission Date 09/10/25. Record review of Resident #1's History & Physical dated 11/17/25 revealed [AGE] year-old female with past medical history of CAD (heart's arteries get clogged with plaque, making them narrow and stiff, so they cannot deliver enough oxygen-rich blood to your heart muscle), DM (a condition where the body has too much sugar in the blood because it does not make enough insulin or cannot use it well), heart failure (the heart muscle becomes weak, stiff, or enlarged, causing blood to back up and fluid to build in the lungs and limbs), COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction), PVD (circulation problem where narrowed or blocked blood vessels outside your heart and brain reduce blood flow to your limbs and organs due to plaque buildup), HTN (when the force of blood pushing against the artery wall is consistently too high, making the heart work harder and straining blood vessels, which increases the risk of heart attack and stroke), prior CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), CKD 3 (kidneys have moderate damage and are not filtering waste and extra fluid as well as they should) , anoxic encephalopathy (is a severe brain injury from a complete lack of oxygen, causing brain cells to die rapidly), who underwent cardiac arrest. Unable to be extubated (removal of breathing tube from the throat and windpipe after being on a ventilator to help with breathing and remains ventilator dependent), tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to bypass a blocked airway, to help with breathing, or remove secretions, providing a direct path for oxygen to the lungs), dysphagia (difficulty swallowing), and peg placement (feeding tube placed directly through the stomach to deliver food, liquids, and medicine). Pt. is bedbound. Stage IV sacral wound, stage IV to left buttocks and right buttocks. Air mattress, change position every two hours, keep area dry with foley (a device that drains urine from the bladder into a collection bag outside of the body when a person cannot urinate on their own or for various medical reasons), Provide heel protectors while in bed. Wound care to evaluate and treat. Interface with nutritional/dietary services. Resident does not follow commands, does not blink to threat, no purposeful movements seen. Social Services for discharge. The resident's family members desire the use of all life-sustaining measures, including, but not limited to cardiopulmonary resuscitation, intubation (a flexible breathing tube placed through the mouth or nose, down into the windpipe to keep the airway open, allowing a machine to help the person breath, deliver oxygen, or remove blockages), use of mechanical ventilation, and use of pressors (are powerful medicines used in emergencies to rapidly raise dangerously low blood pressure by squeezing blood vessels and making the heart beat stronger), We will therefore monitor progress and adjust treatment plan as clinical conditions change. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed reentry date 09/10/25. Section B - B0100. Persistent vegetative state/no discernible consciousness. Section: GG0115 - Functional Limitation in Range of Motion impairment on both sides of upper and lower extremities. Section GG - GG0130. Dependent with toileting hygiene. Indwelling catheter and incontinent of bowel. Active Diagnoses: CAD, heart failure, hypertension, PVD, DM, CVA, COPD, persistent vegetative state (person is awake, eyes opened, sleep-wake cycles, but has lost the ability to think, be aware of themselves or their surroundings, or respond to commands, even though the basic life functions work due to an intact brainstem) , anoxic brain damage (the brain is completely deprived of oxygen, resulting in significant cognitive, physical, and emotional deficits, potentially causing coma or death). Section Q: Family participated in assessment and goal setting. Q0310. Resident's Overall Goal was left blank. Q0400. Discharge Plan. Is active discharge planning already occurring for the resident to return to the community? No. Q0610, Referral. Has a referral been made to the Local Contact Agency? No. Q0620, Reason Referral to Local Contact Agency (LCA) not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent with bowel and bladder received appropriate treatment and services to prevent urinary tract infections for 2 (Resident #1 and Resident #2) of 4 residents reviewed for incontinence care. - The facility failed to ensure Resident #1's and Resident #2's foley catheter drainage tubes were secured with Catheter Holder prior to turning & repositioning the residents in bed. - The facility failed to ensure CNA B provided perineal care according to facility policy and procedure for Resident #1 when she failed to clean the perineal area from front to back when providing perineal care on 12/18/25. These failures placed residents at risk for the development and/or worsening of urinary tract infections and dislodgement of the foley catheter. Findings included:Resident #1Record review of Resident #1's admission Record revealed Original admission Date 05/28/25 and re-admission Date 09/10/25. Record review of Resident #1's History & Physical dated 11/17/25 revealed [AGE] year-old female with past medical history of CKD 3 (kidneys have moderate damage and are not filtering waste and extra fluid as well as they should) change position every two hours, keep area dry with foley (a device that drains urine from the bladder into a collection bag outside of the body when a person cannot urinate on their own or for various medical reasons).Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed reentry date 09/10/25. Section B - B0100. Persistent vegetative state/no discernible consciousness. Section: GG0115 - Functional Limitation in Range of Motion impairment on both sides of upper and lower extremities. Section GG - GG0130. Dependent with toileting hygiene. Indwelling catheter and incontinent of bowel. Review of Resident #1's Care Plan dated 12/15/25 revealed resident was incontinent of bowel. Goal: The resident will not have any complications r/t bowel incontinence. Interventions: Provide perineal care after each incontinent episode. Resident #1 has an ADL Self-Care performance deficit: Toilet use: requires staff x 2 for assistance. The Care plan did not address Resident#1 had a foley catheter. Review of Physician's Order Summary for Resident #1 revealed, Order Date: 10/17/25 Urinary Catheter using 16 FR (the size of the tube)/10 ml bulb to gravity drainage every shift related to neuromuscular dysfunction of bladder (a nerve damage from injury or disease that the signals between your brain and bladder muscles to be interrupted, making it hard to hold or release urine, causing incontinence, sudden urges, or inability to empty fully), Provide catheter care every shift. During an observation and interview on 12/18/25 at 1:07 PM with RN A Treatment Nurse and CNA B, revealed Resident #1 had an EBP sign posted on the wall by the entrance to the resident's room. Upon entering the room, the nurse and CNA washed their hands and put on a gown and gloves. The resident was asleep in bed, lying on her back. Resident's indwelling catheter was draining light yellow urine, and the drainage bag was hanging from the bed frame and was stored in a dignity bag. It was observed that the Catheter Holder was loose and hanging on the catheter tubing. The tube feeding was turned off and the CNA lowered the HOB. When CNA B released the tabs on the side of the disposable brief, it was observed that the wound dressing on the sacral area was intact and had loose fecal matter on the edges of the dressing. It was observed that the brief was saturated with loose brown stool covering the pubis area (the rounded, fatty mound above the genital that gets pubic hair) and buttocks. The RN and CNA placed a disposable pad under the resident. The brief was rolled down towards the rectal area and the CNA started to clean the resident with pre-moistened cleaning wipes from back to front with the cleaning wipes that were full of loose stool. She again cleaned the resident's pubis area using clean wipes and again cleaned the resident from back to front. The RN assisted the CNA to turn the resident to the left side and continued to clean the buttocks, rectal area and inner thighs with cleaning wipes. The CNA used multiple clean wipes after each stroke to clean the resident, until the resident was clean for the treatment nurse to proceed with wound care. The CNA said, The Catheter Holder comes off when the residents are showered or when cream is applied. I will let the nurse know that the Catheter Holder needs to be replaced.During An interview on 12/18/25 at 1:36 PM CNA B revealed she had been trained in providing Perineal Care to incontinent residents. She said she was trained to wipe the female residents working from front to back, using pre-moistened cleansing wipes to protect the small opening at the tip of the urethra and the vaginal opening from fecal matter to prevent cross contamination and infection; clean the inner thigh with cleaning wipes, and if a resident has a foley catheter to clean the catheter tubing with clean pre-moistened wipes. She said they had been trained to make sure the foley catheter tubing was placed in the Catheter Holder located on the top part of the inner thigh to prevent injury to the urethra when moving the resident in

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hire a qualified full-time social worker in a facility with more than 120 beds. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure a facility with more than 120 beds employed a qualified social worker on a full-time basis. The facility failed to have a full-time social worker since 12/11/25, to address Grievances and complete Discharge Plans. This failure put facility residents at risk of not having their psychosocial or discharge planning needs met. Findings included:Record review of Resident #1's admission Record revealed Original admission Date 05/28/25 and re-admission Date 09/10/25. Record review of Resident #1's History & Physical dated 11/17/25 revealed [AGE] year-old female with past medical history of CAD (heart's arteries get clogged with plaque, making them narrow and stiff, so they cannot deliver enough oxygen-rich blood to your heart muscle), DM (a condition where the body has too much sugar in the blood because it does not make enough insulin or cannot use it well), heart failure (the heart muscle becomes weak, stiff, or enlarged, causing blood to back up and fluid to build in the lungs and limbs), COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction), PVD (circulation problem where narrowed or blocked blood vessels outside your heart and brain reduce blood flow to your limbs and organs due to plaque buildup), HTN (when the force of blood pushing against the artery wall is consistently too high, making the heart work harder and straining blood vessels, which increases the risk of heart attack and stroke), prior CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), CKD 3 (kidneys have moderate damage and are not filtering waste and extra fluid as well as they should) , anoxic encephalopathy (is a severe brain injury from a complete lack of oxygen, causing brain cells to die rapidly), who underwent cardiac arrest. Unable to be extubated (removal of breathing tube from the throat and windpipe after being on a ventilator to help with breathing and remains ventilator dependent) and remains ventilator dependent, tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to bypass a blocked airway, to help with breathing, or remove secretions, providing a direct path for oxygen to the lungs), dysphagia (difficulty swallowing), and peg placement (feeding tube placed directly through the stomach to deliver food, liquids, and medicine). Pt. is bedbound. Stage IV sacral wound, stage IV to left buttocks and right buttocks. Air mattress, change position every two hours, keep area dry with foley (a device that drains urine from the bladder into a collection bag outside of the body when a person cannot urinate on their own or for various medical reasons), Provide heel protectors while in bed. Wound care to evaluate and treat. Interface with nutritional/dietary services. Resident does not follow commands, does not blink to threat, no purposeful movements seen. Social Services for discharge. The resident's family members desire the use of all life-sustaining measures, including, but not limited to cardiopulmonary resuscitation, intubation (putting a breathing tube through the mouth down into the windpipe to help breath), and use of pressors (powerful drugs used to raise dangerously low blood pressure, to ensure vital organs get enough oxygen and blood flow) we will therefore monitor progress and adjust treatment plan as clinical conditions change. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed reentry date 09/10/25. Section B - B0100. Persistent vegetative state/no discernible consciousness. Section: GG0115 - Functional Limitation in Range of Motion impairment on both sides of upper and lower extremities. Section GG - GG0130. Dependent with toileting hygiene. Indwelling catheter and incontinent of bowel. Active Diagnoses: CAD, heart failure, hypertension, PVD, DM, CVA, COPD, persistent vegetative state (person is awake, eyes opened, sleep-wake cycles, but has lost the ability to think, be aware of themselves or their surroundings, or respond to commands, even though the basic life functions work due to an intact brainstem) , anoxic brain damage (the brain is completely deprived of oxygen, resulting in significant cognitive, physical, and emotional deficits, potentially causing coma or death). Section Q: Family participated in assessment and goal setting. Q0310. Resident's Overall Goal was left blank. Q0400. Discharge Plan. Is active discharge planning already occurring for the resident to return to the community? No. Q0610, Referral. Has a referral been made to the Local Contact Agency? No. Q0620. Reason Referral to Local Contact Agency (LCA) not made code 3 Referral not wanted. Review of Resident #1's Care Plan dated 12/15/25 revealed the resident did not have a Discharge Plan. Review of Discharge Notice dated 11/26/25 for Resident #1 revealed, written notification that resident will be discharged from the nursing facility effective thirty-one days from the receipt of this letter. The effective date of discharge is 12/26/2025. This discharge is based on your failure, after reasonable and appropriate notice, to pay for provided services and your stay at this facility. The facility staff

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections for 1 of 4 residents (Resident #3) reviewed for Enhanced Barrier Precautions. The facility failed to implement their policy on Enhanced Barrier Precautions during high contact resident care activities for Resident #3 who had a wound and indwelling medical device. This failure could place residents at risk for healthcare associated cross-contamination and at risk of the transmission of multi-drug-resistant organisms (MDROs). The findings included:Record review of Resident #3's admission Record revealed Original admission Date 07/22/21 and re-admission Date 04/12/25. Record review of Resident #3's History & Physical dated 04/14/25 revealed [AGE] year-old female with past medical history of frequent UTIs (a common bacterial infection in any part of the urinary system). Assessment: Indwelling foley catheter (a device that drains urine from the bladder into a collection bag outside of the body when a person cannot urinate on their own or for various medical reasons), Peg tube (feeding tube placed directly through the stomach to deliver food, liquids, and medicine). Record review of Resident #3's Quarterly MDS dated [DATE] revealed, BIMS Score of 2 (severe cognitive impairment), dependent (resident does none of the effort to complete the activity) with toileting hygiene, shower, and personal hygiene. Dependent with turning & repositioning in bed and transfers to shower, indwelling catheter, incontinent of bowel, Feeding Tube (G-Tube). Record review of Resident #3's Care Plan dated 09/19/25 revealed, Resident was incontinent of bowel. Provide incontinent care PRN. Resident has an indwelling catheter. Ensure tubing is anchored to the resident's leg or linens so that tubing is not pulling. Resident has a feeding tube. Clean insertion site daily as ordered. Monitor for sign and symptoms of infection or breakdown. The Care Plan did not document Resident #3 was on EBP. Record review of Resident #3's Physician Order Summary dated 12/19/25 revealed, Enteral Feed Order via G-tube three times a day. Cleanse stage 2 pressure ulcer to LLE with wound cleanser, pat dry, and apply skin prep, cover with dry dressing Tuesday, Thursday, Saturday and PRN. Resident is on Hospice. The physician's order did not document Resident #3 was on EBP. During an interview on 12/18/25 at 1:45 PM CNA C revealed they had been trained on EBP and are supposed to use a gown and gloves when providing direct care to those residents that have pressure ulcers, catheters, feeding tubes, to prevent cross contamination of uniforms and spread of infections.During an interview on 12/18/25 at 1:49 PM LVN Charge Nurse D on the 400 Hall revealed the staff had been trained on EBP, signs are posted in the hall by the entrance to the resident rooms, and PPE as kept by the door as you entered the room. The staff should use a gown, gloves, and goggles as needed when direct care was provided to the residents to prevent cross contamination of their uniforms and prevent the spread of infections. During an observation on 12/19/25 at 9:30 AM with LVN H and CNA I, there was an EBP sign posted on the wall in the hallway by the entrance to Resident #3's room. The Nurse and CNA entered the room, did not wash their hands and did not put on a gown or gloves before having direct contact with the resident. The resident was turned to the left side using the sheet, CNA untied the tags on the side of the brief. It was observed that the resident was clean and dry. There was no redness noted on the buttocks or sacral area. The nurse and the CNA washed their hands and left the room. During an interview on 12/19/25 at 9:33 AM LVN H revealed they had been trained on EBP and she got nervous and forgot to wash her hands when they entered the room and forgot to follow EBP and did not put on an isolation gown and gloves prior to having direct contact with the resident. She said the resident had a G-tube, pressure ulcer on one of the heels, and was incontinent of bowel and bladder. She said that failure to follow EBP placed the staff and residents at risk of cross-contamination and spread of infections. During an interview on 12/19/25 at 9:39 AM, CNA I, in the presence of LVN H Charge Nurse, said EBP was no longer needed for Resident #3 because her catheter had been discontinued. The LVN, said, The catheter was discontinued. However, the resident still needs to be on EBP because she had a G-Tube and pressure ulcer. The CNA, said I was rushing to get residents up for the scheduled Christmas activity this morning and forgot to follow EBP when I entered [Resident #'3] room to assist LVN H turn the resident to the side to check the resident's skin on her buttocks for skin breakdown. During an interview on 12/19/25 at 9:51 AM DON stated the licensed staff and CNAs had been trained on EBP to reduce transmission of multidrug-resistant organisms, and the staff should use a gown and gloves during high contact resident care activities. He said