| 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 | 02/04/2026 |

| 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.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 2 of 2 residents (Residents #1 and #2) reviewed for records.The facility failed to provide an accurate report to HHSC on self-reportable incidents.This deficient practice could place residents at risk of not having accurate documentation and put residents at risk for further incidents of abuse or neglect.Findings include:Record review of Resident #1's face sheet, dated 02/03/2026, revealed an [AGE] year-old female with initial admission date of 11/14/25 and re-admission date of 12/20/25.Record review of Resident #1's health and physical, dated 12/30/25, revealed a medical history of: Hypertension (high blood pressure) and Dementia (a term used to describe a group of systems affecting memory, thinking, and social abilities).Record review of Resident #1's Prospective Payment System MDS, dated [DATE], revealed a BIMS of 7, which indicated severe cognitive impairment.Record review of Resident #1's Event note dated 12/25/25 noted Resident #1 was observed with swelling to her ankle, and Resident #1 denied pain. Physician and Responsible Party were notified per Event note.Record review of Resident #1's Trauma Informed PRN assessment dated [DATE] noted no negative findings.Record review of Resident #2 face sheet dated 02/03/26 revealed an [AGE] year-old female resident with initial admission date 05/08/25 and re-admission date 09/10/25.Record review of Resident #2's health and physical, dated 02/03/26, revealed a medical history of: Type 2 Diabetes Mellitus (a chronic condition that is characterized by high levels of sugar in the blood), Cerebrovascular Disease (a term used for conditions that disrupt blood flow to the brain, such as a stroke, which can cause brain damage), Anoxic Brain Damage (occurs when the brain is deprived from oxygen leading to potential permanent brain injury), and Sarcopenia (age-related loss of muscle mass and strength).Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 was unable to participate in BIMS.Record review of Provider Investigation Report for incident intakes did not include detailed information such as interviews conducted, what documentation was reviewed, or what interventions the facility took to correct or prevent further incidents. This included the following separate intakes involving Residents #1 and #2.In an interview on 02/04/26 at 10:48 AM with the DON, he stated Resident #1 had interventions implemented and included in the care plan after Resident #1's fall on 12/25/25, which included pain medication management, therapy evaluation, and compression to Resident #1's ankle. He stated the Physician and family were notified after Resident's #1's fall, and then again on 01/22/26 after swelling was observed and reported to nursing staff. He stated the nursing staff, which included CNA's and Nurses, the resident, and Therapy staff were interviewed as part of the facility's investigation. He stated the Administrator was to speak immediately with the resident during an incident, and the Social Worker completed the Trauma Informed Assessment on the resident. He stated the Social Worker would also did random audit checks for ANE with the residents, especially in the hall where the incident or allegation took place. He stated as the<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 |
|---|---|---|

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DON he also interviewed and trained staff on ANE. The DON stated staff were to complete an incident report after being made aware of an incident or allegation, which would be supporting documentation for the extent of the incident and cause. He stated it also included the Event Note and the progress notes in the resident's chart. He stated himself as the DON, and the Administrator were responsible for completing the Provider Investigation Report, and the Administrator reviewed it before finalizing and sending it to HHSC. The DON stated the Provider Investigation Report was vague and not detailed. He stated the documentation did not show the interventions discussed.In an interview on 02/05/26 at 4:04 PM with the Administrator, she stated Resident #1 did not complain of pain when the ankle fracture was discovered on 01/22/26, and it was the CNA's who reported an observation of swelling to the nurses. She stated the CNAs were showering Resident #1 when the observation was made. She stated Resident #1 was bed bound, so the day the ankle fracture was most likely in bed that day. She stated there were no changes in behavior before the fracture was discovered. The Administrator stated she had a history of falls and had a fall during her stay in the facility. She stated she was unable to recall what interventions Resident #1 had in place for the fall prevention. She stated the Physician and Responsible Party were notified for both incidents via phone. She stated the Physician ordered an X-ray on 01/22/26, which showed the fracture and Resident #1 was referred to her Orthopedist. She stated the residents and staff were interviewed as part of the investigation conducted by the facility. She stated the facility investigations also included identifying the time frame of the incident, changes in behaviors, and staff that worked the shift the incident took place. She stated ANE was determined by interviewing the resident, getting witness statements, and other interviews, taking pictures if applicable, and reviewing documentation such as progress notes. The Administrator stated Resident #1 was unable to answer questions due to her Dementia. She stated the DON was responsible for interviewing staff. The Administrator stated supporting documentation would include lab results, patient history, and progress notes. The Administrator stated she did not document her investigation into the residents' charts or in the report; she stated she had a personal notebook where she documented her investigations and findings. She stated she understood that documentation not included in residents' charts would cause the possible risk for stopping continuity of care to the residents, and staff would not be aware of what occurred. She stated the documentation provided to HHSC, which included the Provider Investigation report, was not complete or detailed. She stated it didn't include the interventions the facility took noted in the documentation. She stated she was responsible for completing the Provider Investigation report as the Administrator. She stated self as the Administrator and the DON reviewed documentation before finalizing and sending documentation to HHSC.Record review of the facility's, undated, policy Abuse, Neglect, Exploitation, read in part: F. Investigation- Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. and continued to read, 3. A report to the appropriate agency will include the following: E. The nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injury of unknown source. F. The nursing facility will make an addendum to any reportable incident in its report to HHSC if the resident subsequently experiences a negative outcome. G. Other pertinent information is available. The written report must be sent to HHSC . Lastly, it read, 6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personal action deemed necessary. Record review of the Texas Health and Human Services Commission document, Long-Term Care Regulation Provider Letter, undated, read in part under 2.0 Policy Details & Provider Responsibilties: A provider must: ensure a thorough investigation is conducted<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and documented in the PIR . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #1) reviewed for care plans.The facility failed to have a comprehensive person-centered care plan for Resident #1 to address the fall that occurred in the facility on 12/25/25.This failure could place residents at risk for not receiving care and services to meet their needs.Findings Include:Record review of Resident #1's face-sheet, dated 02/03/2026, revealed an [AGE] year-old female with initial admission date of 11/14/25 and re-admission date 12/20/25.Record review of Resident #1's health and physical, dated 12/30/25, revealed a medical history of: Hypertension (high blood pressure) and Dementia (a term used to describe a group of systems affecting memory, thinking, and social abilities).Record review of Resident #1's Prospective Payment System MDS, dated [DATE], revealed a BIMS of 7, which indicated severe cognitive impairment.Record review of Resident #1's care plan, with revision date 01/30/26, revealed Resident #1's fall was not included. Resident #1's care plan noted she was a risk for falls related to impaired mobility included interventions for staff: anticipate and meet resident's needs; be sure the call light within reach and encourage resident to use it for assistance needed; and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. In an observation on 02/03/26 at 09:05 AM, Resident #1 was in her bed with the bed in the lowest position with call light within reach. Resident #1 did not answer this State Surveyor when asked if she would answer questions regarding the Nursing Facility's care or services.In an interview on 02/04/26 at 09:54 AM with the MDS nurse, she stated Resident #1's fall that occurred in the facility should have been included in the care plan. She stated a fall would be considered a change of condition and would need to be updated and added to the resident's care plan. She stated care plans were individualized to the resident and were to make staff aware of the resident's history and how to provide care for that resident. She stated the ADON's were responsible for making acute changes to the resident's care plan. She stated MDS monitored residents' care plans quarterly, or as needed for significant changes which she would be responsible for updating the care plan at that time. The MDS nurse stated the possible risk to Resident #1 not having their fall included in the care plan could increase risks for future falls.In an interview on 02/04/26 at 10:55 AM with the DON, he stated Resident #1's fall was considered a change of condition that should have been included in the resident's care plan. He stated the nursing department, nurses, were responsible for monitoring the care plan and were to update it for acute changes such as Resident #1's fall. The DON stated MDS nursing were to review resident care plans quarterly, but they monitored daily. He stated the possible risk for Resident #1's fall not being on the care plan included risk for future falls and injuries to the resident. The DON stated Resident #1's fall was to be updated to the resident's care plan to address the fall that Resident #1 had on 12/25/25. He stated it was to prevent the risk for future falls and have staff aware of Resident #1's history.In an interview on 02/05/26 at 4:10 PM with the Administrator, she stated the care plan painted a picture of the residents' needs. She stated it provided information to all facility staff regarding the residents' care. She stated MDS nursing monitored care plans overall, which were reviewed quarterly. She stated if there was a change of condition, the care plan was to be updated immediately by the nursing staff. The Administrator stated the risk of not including Resident #1's fall included the resident having additional falls.Record review of the facility's,<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | undated, policy Comprehensive Care Planning, read in part: The facility will develop and implement a comprehensive care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. It also read, The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**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 #2) reviewed for transmission-based precautions.The facility failed to ensure the Wound Care RN provided wound care per facility policy on 02/04/26.This deficient practice could place residents at risk of exposing them to care that could lead to the spread of infections.Findings include:Record review of Resident #2 face sheet, dated 02/03/26, revealed an [AGE] year-old female with an initial admission date of 05/08/25 and re-admission date 09/10/25.Record review of Resident #2's health and physical, dated 02/03/26, revealed a medical history of: Type 2 Diabetes Mellitus (a chronic condition that is characterized by high levels of sugar in the blood), Cerebrovascular Disease (a term used for conditions that disrupt blood flow to the brain, such as a stroke, which can cause brain damage), Anoxic Brain Damage (occurs when the brain is deprived from oxygen leading to potential permanent brain injury), and Sarcopenia (age-related loss of muscle mass and strength).Record review of Resident #2's MDS revealed Resident #2 was unable to participate in the BIMS. Section M- Skin Conditions notated Resident #2 had pressure ulcers and Skin Treatments included Wound Care.Record review of Resident #2'sphysician order, dated 02/03/26, notated: Stage 4 Pressure Wound of the Left Buttock required Daily and PRN wound care; Stage 4 Pressure Wound of the Right Buttock required Daily and PRN wound care; and Stage 4 Pressure Wound of the Sacrum required Daily and PRN wound care.Record review of Resident #2's Wound Care progress note, dated 02/03/26, revealed all wound sites were observed and noted to be healing as evidenced by decreased depth of wounds, with no signs of infection noted.Record review of Resident #2's care plan, with revision date 02/04/26, revealed Resident #2 had pressure ulcers or potential for pressure ulcer: Stage 4 pressure wound to Right Buttock; Stage 4 pressure wound to Left Buttock; and Stage 4 pressure wound to Sacrum. Interventions for facility staff included Administering Arginaid as ordered.In an observation on 02/04/26 at 09:44 AM of Resident #2 revealed he was in his bed. Resident #2 was unable to answer questions due to his medical condition.In an observation and interview on 02/04/26 at 09:46 AM revealed Wound Care RN provided Resident #2 with wound care. Resident #2's left buttock and right buttock were observed. Resident #2's Left and Right Buttock's wound was observed; each wound was approximately 0.5 inch in length and width. No redness or swelling observed on either wound. The Wound Care RN stated wound care was ordered daily and as needed for Resident #2 and she observed an improvement in his healing on all sites. The Wound Care RN was observed applying powder medication, Arginaid which was a powder-form nutritional supplement designed to support wound healing, on Resident #2's Right and Left Buttock. The Arginaid powder applied onto Resident #2's Right and Left Buttock wound, and then the powder medication was observed to spill from the wound during wound care, onto Resident #2's brief. The Wound Care RN then secured the brief on Resident #2, with the medication opened and spill still on the brief.In an interview on 02/05/26 at 3:15 PM with the DON, he stated Wound Care nurses were responsible for ensuring to provide wound care per facility policy. He stated as the DON, he was responsible for monitoring wound progress notes, which was done weekly. He stated it was not acceptable for the Wound Care RN to not change the brief with contaminated powder medication. He stated the possible risks of leaving a brief on Resident #2 with the contaminated spilled medication on the brief could include possible infection or illness to the resident, as it could also infect the other wounds Resident #2 had.Record review of facility's, undated, policy Wound Treatment Management, read in part: Policy: To promote wound healing of various<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. It continued 1. Wound treatments will be provided in accordance with physician orders . 3. Dressing changes may be provided outside the frequency paramaters in certain sitiuations: a. Feces has seeped underneath the dressing. B. the dressing dislodged. C. the dressing is soiled or otherwise is wet. |