

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 four of four community shower rooms, and for one (Resident #2) of four Resident Rooms reviewed for infection control. -The facility failed to ensure clean linen carts were not stored in the community shower rooms where they stored the dirty linen hampers that were full of soiled linen and were not completely sealed. -The facility failed to ensure nursing staff were not storing Resident #2's soiled clothing on the floor in the resident's closet. These failures could result in increased risk of infection to residents. Findings include: Community Showers:During an observation and interview on 07/15/26 at 12:27 p.m. with the Maintenance Director in the shower room in the 500 Hall it was revealed there were 10 dirty linen hampers that contained soiled linen that were not completely covered, and a clean linen cart stored in the shower room. It was observed that the linen cart cover was worn out and the sides of the cart cover were not sealed to prevent cross contamination of the clean linen, gowns, and disposable briefs. The Maintenance Director said that he was not aware that the nursing staff were storing the clean linen carts in the shower rooms.During an observation on 07/15/26 at 12:38 p.m. with the Maintenance Director in the shower room in the 400 Hall revealed there were two clean linen carts stored in the shower room. One of the linen carts that contained gowns, sheets, pillowcases and blankets was uncovered. There were two dirty linen hampers that were full of dirty linen, and one of the hampers was not completely sealed. There was a gallon of body wash stored on the floor in one of the shower stalls.During an observation on 07/15/26 at 12:45 p.m. with the Maintenance Director in the shower room in the 200 Hall revealed there was a clean linen cart with clean linen that was stored in the shower room and there were three dirty linen hampers stored in a shower stall. The linen cover was worn out, with holes and the sides were not sealed.During an observation on 07/15/26 at 12:46 p.m. with the Maintenance Director in the shower room in the 300 Hall revealed there was a clean linen cart with clean linen stored in the shower room and the sides of the cover on the linen cart were not sealed exposing the clean linen. There was a wet towel on top of the right side of the linen cart.During an interview with CNA H on 07/15/26 at 2:18 p.m. on the 6-2 shift she said the CNAs store the clean linen hampers and the dirty linen hampers in the shower rooms when not in use. She said that they had been trained to keep the dirty linen hampers completely covered to prevent cross contamination.During an interview with the DON on 07/15/26 at 3:00 p.m. revealed that the clean linen carts and dirty linen hampers were stored in the shower rooms when not in use. She said the staff had been trained to keep the clean linen carts covered and dirty linen hampers completely sealed to prevent cross contamination. She said the nursing administration were responsible for infection control and monitoring of cross contamination. Resident #2Review of Resident #2's admission Record (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 07/16/26 revealed Resident #2 was admitted on [DATE]. Review of the History & Physical dated 04/15/26 for Resident #2 revealed he was an [AGE] year-old male with past medical history of dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation) and Cognitive Communication Deficit (Difficulty with speech, reading, writing, or listening caused by underline brain based thinking skills). Review of Quarterly MDS dated [DATE] for Resident #2 revealed, unclear speech, rarely makes self-understood and rarely understands others. Short-term and Long-term Memory problems. Frequently incontinent of urine. Incontinent of bowel. Active Diagnoses: Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life). Review of Care Plan revised 06/26/26 for Resident #2 revealed: -Resident has impaired thought process r/t Dementia. Interventions: Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. -Resident has a communication problem due to language barriers. Interventions: Anticipate and meet needs. The resident can communicate by using a communication board. -Resident is incontinent of bowel & bladder. Interventions: Incontinent care at least every two hours. During an observation and interview on 07/15/26 at 2:39 p.m. with LVN ADON A revealed there was a sign posted on Resident #2's closet door that said the resident's family washed the resident's clothes. When the ADON opened the closet door, there was a soiled pair of sweatpants and a shirt lying on the floor. There was a strong urine odor in the closet. LVN ADON A said that they had asked the family to bring a container to place the soiled clothing in until they came to pick it up to take home to wash and the family never brought a container. She said the staff had been trained not to place soiled personal clothing on the floor in the closets and had been trained to place the soiled clothing in plastic bags to prevent cross contamination. During an observation and interview on 07/16/26 at 8:48 a.m. with LVN ADON C of Resident #2's closet revealed there was one pair of sweatpants on the floor that was wet with urine, and there were two plastic bags that contained soiled clothing stored on the floor in the resident's closet. The ADON said the staff had been trained not to place soiled clothing on the floor in the closets for those residents whose families do the laundry for the residents to prevent urine odor in the room and prevent cross contamination. ADON C said the DON and ADONs were responsible for Infection Control. During an interview on 07/16/26 at 1:28 p.m. with CNA F on the 2-10 shift revealed the family of Resident #2 took his soiled personal clothing to wash. She said that they placed the soiled clothing in plastic bags and stored them on the floor because the resident did not have a container to place the bags of dirty clothes. She said they had been trained not to store anything on the floors to prevent cross contamination. During an interview on 07/16/26 at 1:34 p.m. with CNA G on the 2-10 shift revealed that Resident #2 was confused, required total assistance with ADLs, and was incontinent of bowel & bladder. She said that the resident's family washed his personal clothes and they placed the resident's soiled clothing in plastic bags and placed the plastic bags on the floor in the resident's closet for the family to pick up when they came to see the resident. She said that they did not have a container in the resident's closet to place the plastic bags that contained soiled personal clothing. She said they had been trained not to place anything on the floor to prevent cross contamination. Review of facility's undated policy and procedures on Fundamentals of Infection Control Precautions revealed: A variety of Infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions to prevent the transmission of infection: Hand Hygiene, Gloving, Resident care equipment and articles. It is important that practices reflect the most current CDC guidelines.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all essential equipment in safe operating condition, for 4 of 12 water heaters. The facility failed to maintain 4 of 12 water heaters that provided hot water to 4 of 4 resident units resulting in the water heaters being not operational for over a month. This failure could place the residents at risk of an unsafe environment by not maintaining mechanical equipment in safe operational condition. Findings included: Review of the Water Temperature Logs provided by the Maintenance Director on 07/15/26 revealed the hot water temperatures had not been checked weekly since May 2026 to present. During an interview and record review on 07/15/26 at 3:55 p.m. with the Maintenance Director said they had been having problems with not having hot water in the community shower rooms because one tankless water heaters was down in 4 of 4 resident halls. Review of Estimate from Heating/Air Conditioning company dated 06/19/26 for two tankless water heaters. Review of Estimate from Heating/Air Conditioning company dated 06/19/26 for two tankless water heaters for the 300 Wing. He said, The Administrator is aware of the problem, and I have been working on getting 3 quotes for several weeks as required by company policy to plan for a contractor to come and fix the tankless water heaters in the facility. He said that so far, he only had obtained two quotes. During an interview and record review on 07/15/26 at 4:01 p.m. with the Maintenance Director, he said that he checked hot water temperatures once a week and he had not identified any problems with not having hot water in the shower room in the 500 Hall. Copies of the hot water temperatures checks from May 2026 to present were requested. He said, I need to go and look for them because, I am still in the process of organization my office because the previous maintenance director left a mess. The Maintenance Director provided copies of two quotes to fix the water heaters. One of the quotes was blank and did not have a date or the vendors name. During an observation and interview on 07/15/26 at 4:11 p.m. with the Maintenance Director, it was revealed that the hot water temperature in the shower room in the 200 Hall shower stall was 88.3 degrees Fahrenheit. He said, There are four waterless tanks in the mechanical room in the 200 Hall, and one tankless water heater has not been working for several weeks. During an observation and interview on 07/15/26 at 4:17 p.m. with the Maintenance Director, it was revealed that there were 4 tankless water heaters in the mechanical room in the 200 Hall and one water heater was turned off. He said, It is turned off because it has not been working for several weeks. It was observed that the tank was labeled Replace. During an observation and interview on 07/15/26 at 4:19 p.m. with the Maintenance Director, it was revealed that there were 4 tankless water heaters in the mechanical room in the 300 Hall and one water heater was turned off. He said, It is turned off because it has not been working for several weeks. It was observed that that he attempted to turn the water heater on and kept getting an error message. It was observed that the tank was labeled Replace. During an observation on 07/15/26 at 4:22 p.m. with the Maintenance Director, revealed the hot water temperature in the shower room in the 300 Hall was 103.3 degrees Fahrenheit. During an observation on 07/15/26 at 4:24 p.m. with the Maintenance Director, it was revealed the hot water temperature in the shower room in the 500 Hall was 84.7 degrees Fahrenheit. During an observation and interview on 07/15/26 at 4:26 p.m. with Maintenance Director, it was revealed that there were 4 tankless water heaters in the mechanical room in the 500 Hall and one water heater was turned off. He said, It is turned off because it has not been working for several weeks. During an interview and record review on 07/15/26 at 4:33 p.m. with the Maintenance Director he said that he had the water temperature checks sheet in his office. The Maintenance Director said that he did not have any written documentation to show the water temperatures in the Resident Halls 200, 300, 400, 500 and 600, (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen and the laundry had not been checked starting May 2026 to present. He said that water temperatures should be checked once a month. During an interview and record review on 07/15/26 at 4:44 p.m. with the Administrator and Regional Compliance Nurse L they confirmed water temperature checks had not been done since May 2026 to present. The Administrator said that she was not aware that there were 1 of 4 tankless water heaters not working in 4 of 4 resident halls. She said the Maintenance Director needed to get 3 quotes to send to the corporate office for review and approval to contact a vendor to fix or replace the tankless water heaters. She said that she did not know how many quotes the Maintenance Director had obtained. She said that she did not know how often Maintenance checked the water temperatures in the facility.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #2) of 5 Resident reviewed for Resident Rights. The facility failed to ensure Resident #2's dignity was maintained when he was left in urine-soaked clothing, his bedding was urine soaked, and his room had a strong urine smell. This failure put residents at risk of not being treated with dignity and respect and not being care for in an environment the maintains the resident's quality of life. Findings include: Resident #2Review of the admission Record dated 07/16/26 revealed Resident #2 was admitted on [DATE].Review of the History & Physical dated 04/15/26 for Resident #2 revealed an [AGE] year-old male with past medical history of dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation) and Cognitive Communication Deficit (Difficulty with speech, reading, writing, or listening caused by underline brain based thinking skills).Review of Quarterly MDS dated [DATE] for Resident #2 revealed, unclear speech, rarely makes self-understood and rarely understands others. Short-term and Long-term Memory problems. Frequently incontinent of urine. Incontinent of bowel. Active Diagnoses: Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life).Review of Care Plan revised 06/26/26 for Resident #2 revealed: -Resident has impaired thought process r/t Dementia. Interventions: Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.-Resident has a communication problem due to language barriers. Interventions: Anticipate and meet needs. The resident can communicate by using a communication board.-Resident is incontinent of bowel & bladder. Interventions: Incontinent care at least every two hours.During an observation and interview on 07/15/26 at 2:30 p.m. with LVN ADON A and CNA B revealed Resident #2 was lying in his bed, was awake. The ADON said that the resident was Vietnamese and did not speak English. She said the resident and staff communicate with him by pointing to things. There was strong body odor and urine odor in the room. CNA B said that the resident was showered on Monday-Wednesday- Friday on the evening shift. CAN B said, I have not given him a shower today. It was observed that the resident's bed sheet had a dried urine ring measuring approximately 24 inches and the resident's sweatpants had dried urine on the legs down to the knees. The CNA said that she could not remember the last time that she had checked the resident for incontinence. She said they had been trained to check the incontinent residents at the start of the shift, every two hours and as needed. The CNA assisted the resident to pull the sweatpants down and it was observed that the resident did not have any skin irritation or breakdown. The CNA assisted the resident to a standing position and was in the process of telling the surveyor that she would be taking the Resident to room [ROOM NUMBER] to give him a shower and the ADON was standing to the right side by the CNA shaking her head from side to side. The ADON instructed CNAB to take the resident to the shower room in the 300 Hall to give him a shower because they should not be showering residents in other resident rooms.During an observation on 07/15/26 at 2:39 p.m. with LVN ADON A revealed there was a sign posted on Resident #2's closet door that said the resident's family washed the resident's clothes. When the ADON opened the closet door, there was a soiled pair of sweatpants and a shirt lying on the floor. There was strong urine odor in the closet. She said that they had asked the family to bring a container to place the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled clothing until they came to pick it up to take home to wash and the family never brought a container. She said the staff had been trained not to place soiled personal clothing on the floor in the closets and had been trained to place the soiled clothing in plastic bags to prevent cross contamination. During an observation on 07/16/26 at 8:48 a.m. with LVN ADON C of Resident #2's closet revealed there was one pair of sweatpants on the floor that was wet with urine, and there were two plastic bags that contained soiled clothing stored on the floor in the resident's closet. The ADON said the staff had been trained not to place soiled clothing on the floor in the closets for those residents whose families do the laundry for the residents to prevent urine odor in the room and prevent cross contamination. During an interview on 07/16/26 at 1:28 p.m. with CNA F on the 2-10 shift revealed the family of Resident #2 took his soiled personal clothing home to wash. She said that they placed the soiled clothing in plastic bags and stored them on the floor because the resident did not have a container to place the bags of dirty clothes. She said they had been trained not to store anything on the floors to prevent cross contamination. She said that yesterday 07/15/26 she had found resident with dried urine ring on the sheets and his sweatpants and there was strong body and urine odor in the room. She said that she also frequently found soiled disposable briefs in the trash can in the resident's room. She said that they had been trained not to leave the soiled disposable briefs in the trash cans in the resident rooms. During an interview on 07/16/26 at 1:34 p.m. with CNA G on the 2-10 shift revealed that Resident #2 was confused, required total assistance with ADLs, and was incontinent of bowel & bladder. She said that the resident occasionally urinated or had a bowel movement on the floor. She said that they had been trained to check incontinent residents at the start of the shift, every two hours and as needed. She said that they placed the resident's soiled clothing in plastic bags and placed them on the floor in the resident's closet for the family to pick up when they came to see the resident. She said that they did not have a container in the resident's closet to place the plastic bags that contained soiled personal clothing. She said they had been trained not to place anything on the floor to prevent cross contamination. During an interview on 07/16/26 at 1:45 p.m. with CNA D she said she was assigned to Resident #2 on 07/15/26 on the 6-2 shift and said that the last time she had checked if the resident was wet was at 1:00 p.m. on that day. She said they had been trained to check the incontinent residents at least every two hours. She said that she tried to do rounds every two hours, but it depended on the number of CNAs that were working. She said that when there were only 4 CNAs working on the unit, then each CNA was assigned 14 residents and sometimes they did not have the time to check the incontinent residents every two hours. She said that Resident #2 was showered on the 2-10 shift and that was the reason there was a strong urine smell in the room. She said that the resident's mattress also had a strong urine odor and sometimes the CNAs threw soiled briefs in the trash can in the resident's room. She said they had been trained not to leave soiled briefs in the room to keep the rooms from smelling bad. During an interview on 07/16/26 at 2:53 p.m. with Social Worker E revealed that she heard that Resident #2's responsible party had voiced a concern regarding the cleanliness of the room, found soiled briefs in the trash can when she came to visit and found the soiled personal clothing stored in the closet on the floor causing strong urine odor in the resident's room. She said that she was not aware of what the nursing staff had done to address these concerns because she did not know if a Grievance form had been completed by whoever received the family's concern. She said that the Administrator was the Grievance Official and she assigned the Grievances to the appropriate department head based on the allegations that had been reported.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure efforts were made to resolve resident grievances, for 1 (Resident #5) of 5 residents reviewed for grievance resolution. The facility failed to ensure that the grievance filed by Resident #5 on 05/27/26 was resolved when she had complained that the CNAs were showering other residents in her room without her permission. These failures could place residents at risk of feeling that their voices were not being heard or taken seriously and could cause feelings of worthlessness. Findings include: Resident #5 Review of the admission Record dated 07/16/26 revealed Resident #5 was admitted on [DATE]. Review of the History & Physical dated 12/01/25 for Resident #5 revealed an [AGE] year-old female with past medical history of Mild Cognitive Impairment (A condition causing a noticeable decline in memory or thinking skills that is worse than typical age-related changes but not severe enough to interfere with daily life or independent living) and Depression (a serious mood disorder causing persistent sadness, loss of interest, and lack of motivation, affecting how the person feels, think, and act, differing from normal sadness by lasting long periods and interfering with daily life). Review of Physician Progress Note dated 06/01/26 revealed Resident #5 was alert, oriented to person, place, and time. Review of the Annual MDS dated [DATE] for Resident #5 revealed, BIMS Summary Score 9 (cognition moderately impaired). Active Diagnoses: Depression, and Mild Cognitive Impairment. Review of Care Plan revised 06/26/26 for Resident #5 revealed: -Resident has mild impaired cognitive function. Interventions: Identify yourself at each interaction. Keep the resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion. Monitor and report to physician any changes in cognitive function, especially changes in decision making ability, memory recall and general awareness. -Resident has a history of making false accusations. Interventions: Notify Supervisor and Physician of any false allegations. Review of Resident Grievance for dated 05/25/26 revealed Resident #5 reported grievance about her previous roommate using the shower without her permission. Resolved 05/27/26. A summary of the pertinent findings and conclusions: Resident used shower in a room that was no longer assigned to her. What corrective action will be taken to prevent recurrence. Social Worker provided education to resident on boundaries and respecting others space. Social Worker reminded Resident that the room where she showered was no longer assigned to her and therefore could no longer use that specific shower. Resident displayed clear understanding. Date of notification: 05/27/26. During an interview on 07/16/26 at 5:12 p.m. with Resident #5 revealed that she was alert, oriented to person, place, time and situation. She said that the CNAs would bring other residents to shower in her room without her permission and it made her very upset because it was her room. She said, It is my right for me to refuse to allow them to shower other residents in my room, but they pay no attention to me, and they keep bringing patients to shower in my room every day. She said that she had complained about her previous roommate coming to shower in her room. Whoever handled my concern only addressed the concern about my former roommate coming to shower in my room, but nothing has been done about the CNAs still bringing other residents to shower in my room daily, so my concern has been ignored. She said, The people in charge here at the facility are just bull shitters and do not do anything to address my concerns. During an interview and record review on 07/16/26 at 5:39 p.m. with Administrator of the Grievance Binder revealed a Grievance Form dated 05/27/26 for Resident #5 that was completed by the Social Worker. The Grievance form documented Resident #5 had reported a grievance about her previous roommate (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	using her shower without her permission. She said the Grievance had been resolved 05/27/26 by educating the resident's former roommate on respecting other resident's space. The former resident's roommate was reminded that she could not be showering in room [ROOM NUMBER], and the resident had voiced clear understanding. The Administrator said she had talked to Resident #5 several times after the Grievance had been resolved and she had not voiced any concerns about staff showering other residents in her room. She said, I was not aware that the CNAs were showering residents in other residents' rooms including [Resident #5's] room in 508. She said that she was not aware that it took a long time to get hot water in the community shower room in the 500 Hall and that was why the CNAs were showering residents in other resident rooms. There is another community shower in the 300 Hall where the CNAs can shower residents so they should not be showering residents in other residents' rooms. She said that she did not recall if Resident #2's family had voiced any concerns about having a strong smell of urine in the resident's room, finding soiled briefs in the trash can, or staff placing soiled linen on the floor in the resident's room. She said she was responsible for checking that the facility staff were completing a Grievance Form for all concerns reported so that the concerns could be assigned to the appropriate department head to resolve the concerns as soon as possible. Review of the facility's Grievance Policy and Procedure revised on 11/02/2016 provided by the Administrator revealed, The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; And other concerns regarding their Long-Term Care facility stay. The resident has the right to, and the family must make prompt efforts by the facility to resolve grievances the resident may have. Procedure: The facility will notify residents on how to file a grievance orally, in writing or anonymously with postings in prominent locations. The grievance official of this facility is the administrator or their designee. The grievance official will: oversee the grievance process; Receive and track grievances to their conclusion; Lead any necessary investigation by the facility; Issue written grievance decisions to the resident. As needed, the facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. All written grievance decisions will include: The date the grievance was received. A summary statement of resident's grievance. The steps taken to investigate the grievance. A summary of the pertinent findings or conclusions regarding the resident's concern(s). A statement as to whether the grievance was confirmed or not confirmed. Any corrective action taken or to be taken by the facility staff as a result of the grievance. The date the written decision was issued.		

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 07/16/2026
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming and personal hygiene for 1 (Resident #2) of 5 residents reviewed for quality care.-The facility failed to provide incontinent care to Resident #2 according to the comprehensive person-centered care plan.This failure could place residents at risk of not receiving the necessary personal care to maintain the resident's dignity and prevent skin irritation and skin breakdown. Findings include: Review of the admission Record dated 07/16/26 revealed Resident #2 was admitted on [DATE].Review of the History & Physical dated 04/15/26 for Resident #2 revealed an [AGE] year-old male with past medical history of dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation) and Cognitive Communication Deficit (Difficulty with speech, reading, writing, or listening caused by underline brain based thinking skills).Review of Quarterly MDS dated [DATE] for Resident #2 revealed, unclear speech, rarely makes self-understood and rarely understood others. Short-term and Long-term Memory problems. Frequently incontinent of urine. Incontinent of bowel. Active Diagnoses: Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life).Review of Care Plan revised 06/26/26 for Resident #2 revealed: -Resident has impaired thought process r/t Dementia. Interventions: Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.-Resident has a communication problem due to language barriers. Interventions: Anticipate and meet needs. The resident can communicate by using a communication board.-Resident is incontinent of bowel & bladder. Interventions: Incontinent care at least every two hours.During an observation and interview on 07/15/26 at 2:30 p.m. with LVN ADON A and CNA B revealed Resident #2 was lying in his bed, awake. There was strong urine odor in the room. It was observed that the resident's bed sheet had a dried urine ring measuring approximately 24 inches and the resident's sweatpants had dried urine on the legs down to the knees. The CNA said that she could not remember when the last time was that she had checked the resident. She said they had been trained to check the residents at the start of the shift, every two hours and as needed. The CNA assisted the resident to pull the sweatpants down and it was observed that the resident did not have any skin irritation or breakdown.During an interview and record review on 07/16/26 at 10:23 a.m. with the DON and MDS Nurse K revealed that the CNAs were expected to provide incontinent care every two hours according to the resident's care plan. The DON said that the CNAs had been trained to check the incontinent residents every two hours and as needed to prevent skin irritation and breakdown.During an interview on 07/16/26 at 1:28 p.m. with CNA F on the 2-10 shift revealed they had been trained to check the incontinent residents at the start of the shift and every two hours and as needed. She said that yesterday on 07/15/26 she had found Resident #2 with dried urine ring on the sheets and his sweatpants. She said there was strong body and urine odor in the room. She said that she had reported to the ADONs that residents are frequently found with dried urine rings at the start of shift and nothing had been done to address the problem.During an interview on 07/16/26 with LVN I at 1:32 p.m. revealed that he only worked PRN He said the CNAs had been trained to check the incontinent residents at the start of shift, every two hours and as needed. He said that he did not know which residents were incontinent of bowel & bladder.During an interview on 07/16/26 at 1:34 p.m. with CNA G on the 2-10 shift revealed that Resident #2 was confused, required total assistance with ADLs, was incontinent of bowel & bladder. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said that they had been trained to check incontinent residents at the start of the shift, every two hours and as needed. During an interview on 07/16/26 at 1:40 p.m. with CNA J the 2-10 shift assigned to work on the 300/500 Halls revealed they had been trained to check the incontinent residents at the start of the shift, every two hours and as needed. She said that she checked the incontinent residents prior to the end of the shift. During an interview on 07/16/26 at 1:45 p.m. with CNA D said she was assigned to Resident #2 on 07/15/26 on the 6-2 shift and said that the last time she had checked if the resident was wet was at 1:00 p.m. She said they had been trained to check the incontinent residents at least every two hours. She said that she tried check the incontinent residents every two hours, but it depends on the number of CNAs that were working on the unit. She said that when they did not have 5 CNAs, each CNA would be assigned 14 residents and sometimes they did not have the time to check the incontinent residents every two hours. The facility's policy on incontinent care was requested but was not provided prior to exit.		