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	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Teresa Nursing & Rehab Center	10350 Montana Avenue El Paso, TX 79925

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Resident #155 Advance Directives 34486 Resident #97 Advance Directives 07/23/24 12:27 PM DNR per electronic record - no DNR document scanned into miscellaneous documents. 07/25/24 02:44 PM Socual worker [NAME] - adult Som requested DNR. Did requrest for DIN and in itniated DNR request - CUfrrent status is pendin MD signature on the DNR docuemtn. Her compliance nrusing team that if they makde a rfeuest in house to honor the client's desired so - have to get TX OOH DNR - Valid DNR for in house. No completed hospital DNR. It is a catch 22. 07/25/24 03:51 PM DON - if a resident requests refer to SW Resident #259 Advance Directives 07/24/24 08:44 AM Appears that OOH DNR is not signed by MD. Social worker [NAME] - this is not a valid completed - The facity strated the enactment process, DNR and was scanned in . She did revie with [NAME]. Did not notice - will put it up [NAME] for MDs sicnatur and slooks like medical records grabbed it before the MD signed it. The DNR came in 2/21/24 - The faamiy did sign a resquest fo do not recuscutate. DOe htave it .

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 FACILITY Environment 07/25/24 03:40 PM DON regarding oxygen filters - get Rt arersponsible o makding [NAME] ethat oxyven macings are functionion gprooperlly. should be checking the filters. Risk to residednt not ereceiving desired effect of the oxygen. Not Getting enough oxygen, increase risk of infection.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that residents were free from physical restraints that were not required to treat the resident's medical symptoms for 1 (Resident 259) of two residents reviewed for physical restraints. The facility failed to assess whether Resident #259's concave mattress was a restraint before placing it on her bed. This failure put residents at risk of the use of equipment that might restrict their movement. Findings included: Record review of Resident #259's face sheet dated 7/25/2024 revealed she was [AGE] years old and was admitted to the facility 02/13/2024. Record review of Resident #259's quarterly MDS dated [DATE] revealed she had a BIMS of 14 (cognitively intact). She had no potential indicators of psychosis or behavioral symptoms. She had functional limitations in her range of motion on one arm and one leg. She required partial to moderate assistance to move around in bed, to sit up, sit on the side of the bed, stand up and transfer between surfaces. Her diagnoses included respiratory failure. She had not had any falls before or after admission to the facility. She did not have any physical restraints. Record review of Resident #259's care plan dated 04/25/2024 revealed she had a care plan for risk of falls due to confusion. She had a care plan for a 1/8 bed rail to assist with her ADLs. There was no care plan for a concave mattress. Record review of Resident #259's physician's orders on 07/23/2024 revealed none for a concave mattress. Record review of Resident #259's miscellaneous documents and consents on 07/23/2024 revealed no consent for a concave mattress. Record review of Resident #259's assessments on 07/23/2024 revealed none for a concave mattress. In an interview and observation on 07/23/24 at 03:16 PM Resident #259 was lying in bed. Her bed was lowered with a fall mat on one side. It was observed that the mattress on the resident's bed had built up sides creating a scooped or concave surface. The resident stated she did not have the mattress when she first arrived at the facility but that it was put on her bed in early June. She said it bothered her to have the mattress with the high sides because she could now stand because of physical therapy. She said if she wanted to get up, she had to get around the sides of the mattress, which was difficult. She said she was told the special mattress was so she would not fall down. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/24 at 03:25 PM the DON said Resident #259 was assessed on 07/23/2024 to see if the concave mattress was a restraint for her. She said that if the resident wanted to get up and the mattress made it difficult, the mattress would be considered a restraint. She said that based on the assessment of Resident #259 the concave mattress was not a restraint because she could get out of bed without difficulty with the concave mattress in place. The DON said she was not sure if a physician's order was needed for the concave mattress. She said the concave mattress assessment did not state to notify the family. She did not know if the resident's or family's consent was needed to have the concave mattress in place. Record review of Resident #259's Bolster/Concave Mattress assessment dated [DATE] at 4:36 PM revealed that the purpose to the concave mattress was to provide tactile boundaries of the edge of the mattress. The assessment documented that Resident #259 was able to get out of bed with the concave mattress without additional difficulty with the same amount of assistance as she needed to get out of bed with a regular mattress. The assessment stated that the mattress was not a restraint because It does not restrict freedom of movement . Record review of the facility policy Restraints revised 02/01/2007 revealed that restraint usage would be limited to circumstances in which the resident had medical symptoms that warranted the use of restraints. In part, a physical restraint was any equipment adjacent to the resident's body that the resident could not easily remove and that restricted freedom of movement. A physician's order would be necessary to begin a restraint assessment. The resident and/or responsible party would be contacted to discuss the plan of care and obtain informed consent. A physician's order for the restraint would be obtained specifying the type of restraint and length of time the resident was to be in the restraint.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Resident #93 Dementia Care 07/24/24 04:44 PM LOS - 6/25/2024 7/23/2024 Care plan for dementia not in place. BIMS of 13 on 5-day MDS Diagnosis - Receiving Apriprazole for depression MDS 5 day Jun 28, 2024 shows DX - non-Alzheimer's dementia, Depression - no other psych/mood disorder shown. Care Plan - requires antipsychotic - monitor for side effects. Resident #97 Position, Mobility 07/23/24 09:32 AM Resident states they are not doing anything to address her range of motion of arms or legs. MDS Jun 11, 2024 - 5-day - Dependent for Toileting, dressing, Showering did not occur Substantial/maximal assistance - Roll right and Left, sit to lie, sit to stand, transfers. OT - 95 minutes over three days stating 6/7/24 PT - 98 mins over three days starting 6/7/24 No time recorded for Restorative. Order: PT eval completed this date. PT recommends 5X4 weeks to address deficits with the use of ther ex, ther act, NM re-ed, manual therapy, and gait training as tolerated to maximize rehab potential. 05/31/2024 Discontinued 06/07/2024 Care Plans -- for ADLs - Discuss with resident/family/POA care any concerns related to loss of (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independence, decline in function. PT/OT evaluation and treatment as per MD orders. Date Initiated: 06/27/2024 Caare Plan appears incomplete BED MOBILITY: The resident is able to: (Specify) Date Initiated: 06/27/2024 CNA BED MOBILITY: The resident requires (Specify Supervision, cueing, weight bearing assistance, lifter sheet, trapeze) to turn and reposition. 07/25/24 01:58 PM - [NAME] - COTA - Director of Rehabilitation - Returned on 6/6/24 - was evaluated and got discharged for PT on July 18 - Thinks due to change in payer source. PT bed mobility MAX assist - did not meet her goal with - was mod assist with transfers and bed mobility. OT - loks like met some goals - sitting balance, and standing balance. and grooming & hygine. Does happen that people come in and are DC from therapy prior to reaching goals. Nursing may reprot declines to therapy, and MDS do quarterly assessment to identify any decline on funcgtion. At taht point i s communicateed to and therapy will do a screen to see if servicesa re waranted. Do not have a restoraaive program - Discontinued about 4 months ago. Became aware when discharged from theraaapy or LTC therapy - wouodl refr to restorative. Goal of referring to restoraive was to maintain wha tthey had. Differences between restroitive and - and other styatm. Does nto know if nures are on top of it. MDS is pretty good. Different reprot they can pull. Do talek abouit percentages of reports that CNAs are inputing. 07/25/24 02:16 PM [NAME], LVN MDS Case manager - Medicare and 1/2 managed care - when a new resident comes in use - PCC e-mar for diagnoses - Assessments completed by nurse skilled notes, nurse, therapy notes. these are used for 5 day assessment. For the GG pull for Net health used by therapy based on therapy assessment combined with the nursing etc notes. to determine if a resident in functional status will pull documentaiton survey - POC by CNAs, unless on therapy. If there is a big change would interview and observation. Had a few residents that wer on restoritive, - doe not know if the NMDS nurse who handled LT pulled form restoritive documetation. Care plans - The MDS wil tell you which Care Areas - CAAS trigger and show functional status. IDT is invovled in the care plan reveiw will putl up sections by dicipline - itis personalized byt the rsponsible discipline. Posible that a particular care plan compnent is overlooked. We review the care plan and empty interventions/goals. Has not been personalized. Care paln established plan of care while here - soemthing to be folowed while they ar ehere. Potential impact cour [NAME] quetions about whe care need to be provided. to the residetn. Typicall y when a residnet willthe admitting nurse will complete the triggered initial assessments which generates the base line care paln. Baseline time [NAME] is 24 hours. the baseline becomes the basis for comprehansive a care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/25/24 03:00 PM [NAME] CNA - two weeks ago - got a traingin over range o motion - asks if can move hands - does this based on his knowledge - Thinks it was someone from theapy. With [NAME] does ROM with the residen but no wehre in computer to record this. Reprt whn the resident cant doit. if movement is OK don't need to reportit. If there is a change in range omontion shoud repot it. 07/25/24 03:16 PM DON - Appears Care plan was not updated. Nursing ADON or DON is responsible fo updating. No system for triggering incompete care palns. review ofr completementss - no particuar routine for [NAME]. Acute chagnes it syodl be uspdated. ADONS check the care plans whe a resicdnereturns. Care pans for continuation of care for th residnt need - Threat o residnet - dpn kn ow huw to care for her. Basedlina dn comprehensicve are one in the saem. 07/25/24 03:44 PM DON - does not beleive CNAs get training on ROM - Recently discontinued restoraive - Will tell Therapy if ther is a [NAME] in fucntion al status. Determine [NAME] ein functioal statu based on baseline. Baseline is roecorded in care pan. describes what they can do ad how much helppt they need to do [NAME]. Knkow they have moved off base line - CNAs w and nurse need to notive the [NAME] and reportr it - ans that would trigger a reerral to PT. Was a FLoor nutrws when discontinued restoritive. The therapy would assess for .

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #97) of 17 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure that Resident #97's comprehensive care plan included interventions to address urinary tract infection, shortness of breath, hypotension (low blood pressure), impaired cognitive function, cellulitis (skin infection), potential nutritional problem, mood problem, and depression. The facility failed to ensure that Resident #97's comprehensive care plan for a self-care deficit specified which areas of function were to be maintained or improved (such as bed mobility, transfers, or toilet use). This failure could put Resident #97 at increased risk of not having her care needs met. Findings included: Record review of Resident # 97's face sheet dated 07/25/2024 documented she was [AGE] years old was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #97's electronic diagnosis listing accessed 07/25/2024 revealed she had diagnoses including urinary tract infection, acute and chronic respiratory failure with hypoxia (problems with breathing including shortness of breath) and hypotension (low blood pressure). Record review of Resident #97's 5-day MDS assessment dated [DATE] revealed she had a BIMS score of 8 (Moderate Cognitive impairment). She had diagnoses including chronic obstructive pulmonary disease (lung condition that causes breathing problems), and metabolic encephalopathy (Brain disorder caused by chemical imbalance in the blood). She was dependent on staff for toileting, dressing. She required substantial/maximal assistance to move around in bed, stand from sitting, and to transfer between surfaces. She had an impairment in her range of motion in both arms and legs. Record review of Resident #97's care plan initiated 06/27/2024 revealed that there were not interventions in place to address a urinary tract infection, shortness of breath, hypotension (low blood pressure), impaired cognitive function, cellulitis (skin infection), potential nutritional problem, mood problem, and depression. Her care plan for a self-care deficit with the goal of maintaining or improving her current level of function did not specify which areas of function were to be maintained or improved (such as bed mobility, transfers, or toilet use). The interventions were not personalized to reflect her level of function. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/24 at 02:16 PM MDS Nurse K revealed that it appeared that Resident #97's care plan was not personalized after admission. She said that after admission a 5-day assessment was completed by the admitting nurse using skilled notes, nurses notes and therapy notes. The 5-day assessment fed into the initial MDS which included the Care Areas Assessment which were to trigger review for inclusion in the comprehensive care plan. The IDT would then pull up areas of the comprehensive care plan in order to personalize them. She said the purpose of the care plan was to establish a plan of care to be followed while the resident was in the facility. She said the potential impact of an incomplete care plan was that it could raise questions about what care needed to be provided to the resident. In an interview on 07/25/24 at 03:16 PM the DON revealed that it appeared that Resident #97's care plan was not updated. She said that the ADON or DON was responsible for updating the care plan. She said there was no system for identifying incomplete care plans, and no particular routine for reviewing care plans to ensure they were complete. She said the purpose of care plans was to provide continuation of care for the resident's needs. The DON said an incomplete care plan put residents at risk of staff not knowing how to care for the resident. Record review of the facility policy Comprehensive Care Planning (undated) revealed that the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. The facility would document and implement care and services to be provide to the resident to assist in attaining or maintaining his or her highest practicable quality of life.

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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** 34486 Based on observations, interviews, and record review the facility failed to provide necessary services to maintain good grooming and hygiene for a resident who was unable to carry out activities of daily living for 2 (Residents #26 and #29) of 12 residents reviewed for services to maintain good grooming and hygiene. The facility failed to provide personal hygiene for Resident #26 and #29 by not trimming their fingernails. This deficient practice placed residents at risk of poor hygiene and decline in residents' self-esteem. Findings included: Record review of Resident #26 's Face Sheet dated 7/25/2024 revealed he was initially admitted on [DATE] and readmitted on [DATE]. He was [AGE] years old. Record review of Resident #26 's history and physical dated 9/4/2018 revealed he had diagnoses of hypertension, cerebral infarction (stroke), respiratory failure with hypoxia (not having enough oxygen in the blood) and needed for assistance with personal care. Record review of Resident #26 's quarterly MDS assessment dated [DATE] revealed he was unable to respond to the questions asked. It revealed resident he required total assist with ADL's. He was not able to speak and slurred or mumbled words, was rarely or never understood and sometimes understood. It revealed that he had trouble remembering staff names and faces and that he was at a nursing home . Record review of Resident #26 's care plan dated 04/16/2020 addressed the resident's need for assistance with ADLs such as mobility as needed, follow facilities' policies and protocols for the prevention and treatment of skin breakdown, incontinent care. It revealed the resident had an ADL self-care performance deficit with a left side deficit and required 1 to 2 staff participation for incontinence, bathing, personal and oral hygiene. During observation on 7/23/24 at 09:15 AM, Resident #26 was lying on his bed leaning towards his left side. Resident #26 was observed with long finger nails on both of his hands. The surveyor introduced himself to the resident but he was not able to communicate and would only make gutural sounds. In an interview on 07/23/24 at 09:26 AM, CNA A revealed staff trimmed their nails and they asked the resident for permission. If they refused, the CNA reported to the nurse and if the nurse could not convince the resident, they would attempt several times. CNA A said the risk of not cutting a resident's fingernails is they could cut themselves or other residents and staff. CNA A said there was a risk of infection or if their nails were soiled and bacteria grows in their nails and they ate food with their fingers, they could get sick. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/24 at 10:16 AM, LVN B revealed she had been working at the facility for about 2 years. LVN B said she had known Resident #26 since she started working at the facility. LVN B stated resident #26 was verbally limited and he could answer with yes or no. LVN B said that to her knowledge he had refused his nail care very few times. She said the procedure for cleaning, trimming, and filing nails was to get a basin with water, remove debris under the fingernails, get the nail clipper and the file stick and proceed to trim the fingernails. LVN B said for their fingernails they could clip them if the resident was not diabetic. LVN B said resident #26 is diabetic and he can get his fingernails trimmed or clipped but not his toenails; for toenails they had an inhouse podiatrist. The surveyor showed the picture of resident #26's nails and she stated that it was not acceptable for him to have the fingernails that long because he could scratch and cut himself. LVN B stated if he had dirty nails and bacteria grows and he rubbed his eyes or touched his mouth, he could get an infection. In an interview on 07/25/2024 at 11:00 AM, the DON revealed that the nail care was performed during showers. The surveyor showed the picture of resident #26 fingernails and she stated they were not acceptable. The DON said bacteria could grow underneath his nails or he could scratch himself. She said resident # 26 could potentially get sick from bacteria if he ate with dirty hands and nails. Record review of Resident #29 's Face Sheet dated 7/25/2024 revealed he was initially admitted on [DATE] and readmitted on [DATE]. He was [AGE] years old. Record review of Resident #29 's history and physical dated 08/07/2018 revealed he had a diagnosis of hypertension, cerebral infarction (stroke), respiratory failure with hypoxia (not having enough oxygen in the blood) and need for assistance with personal care. Record review of Resident #29 's quarterly MDS dated [DATE] revealed he had difficulties speaking and had trouble communicating with people. It revealed that he had difficulty understanding staff and had issues remembering names. It revealed he had difficulty with hearing in loud situations, sometimes understood and sometimes he could make himself understood with unclear speech. He had a BIMS score of 3 (severe cognitive impairment). Record review of Resident #29 's care plan dated 03/04/2021 addressed the resident's need for assistance with ADLs such as bathing, requiring assistance from 1 to 2 staff, personal hygiene with 1 staff participation and toilet use requiring assistance. During observation on 7/23/24 at 09:20 AM, Resident #29 was sitting on his wheelchair by the door of his room. He had long fingernails. Resident #29 was asked if he wanted to have his fingernails long and if it was his preference. He was observed shaking his head and talking incoherently and mumbling without sense. He was asked if he wished to have his nails trimmed and Resident #29 was not able to provide a clear answer and would only reply with mumbles. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/24 at 09:47 AM, with LVN J revealed she had been working at the facility for 2 years. LVN J said she was familiar with Resident # 29, and she had known him for about 1 year. LVN J said that primarily the CNAs oversee the hygiene of the residents and if needed LVNs and RNs would intervene. LVN J said normally they made a round when they got to the shift, they saw the residents every 2 hours and then in between as needed or if they needed oral care, then another round before they leave for the day. LVN J said that if a CNA observed a resident with long fingernails, they would trim their fingernails and if they had long toenails, they would refer the resident to a podiatrist. LVN J said they were able to trim their fingernails only. LVN J said staff normally trim the residents' fingernails after shower for the nails to be softer and when it was needed, they soaked the nails, so they get softer and then they filed them. LVN J said Resident #29 did not refuse for him to have his fingernails trimmed. Surveyor showed LVN J a picture of Resident #29's fingernails and she said it was not acceptable for him to have his fingernails that long. She said that he could scratch himself and cut his skin and the potential outcome could result in infection due to possible bacteria under his fingernails. Record review of the facilities' policy dated 2003 labeled Nail Care stated in part: nail management is the regular care of toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing and cuticle care and is usually done during the bath. Trim the nails with a clipper, straight across for the toenails and rounded for the fingernails. Smooth the nails with an emery board. 49854 Resident #26 Activities of Daily Living 07/23/24 04:15 PM 07/23/24 10:43 AM 501 resident was observed without his nasal cannula and he had long finger nails. LVN checked for oxygen level and he was at 96. Resident was not on continuous oxygen orders. Resident #29 Activities of Daily Living 07/23/24 03:08 PM [NAME]: resident was on his wheelchair at the entrance of his room. He had challenges when communicating with surveyor and was not coherent. When asked if he was treated with respect by staff and if he liked the food and activities at the facility he said yes to all and mumbled incoherently. Resident looked clean and groomed. Nail care) [NAME] CNA. they do cut their nails and they ask the resident for permission. If they refuse, the CNA reports it to the nurse and if the nurse can't convince the resident, they will attempt several times. Said that the risk of not cutting a resident's fingernails is they can cut themselves or other including staff. there's also a risk of infection or if their nails are soiled and bacteria grows in their nails and they eat food with their fingers, they can get sick.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Teresa Nursing & Rehab Center	10350 Montana Avenue El Paso, TX 79925

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #97) of 3 residents reviewed for treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The facility failed to provide Resident #97 with treatment and services to address her limited range of motion. This failure could put Resident #97 at increased risk of contractures and impaired skin integrity. Findings included: Resident #97 Record review of Resident # 97's face sheet dated 07/25/2024 documented she was [AGE] years old was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #97's 5-day MDS assessment dated [DATE] revealed she had a BIMS score of 8 (Moderate Cognitive impairment). She had diagnoses including chronic obstructive pulmonary disease (lung condition that causes breathing problems), and metabolic encephalopathy (Brain disorder caused by chemical imbalance in the blood). She was dependent on staff for toileting, dressing. She required substantial/maximal assistance to move around in bed, stand from sitting, and to transfer between surfaces. She had an impairment in her range of motion in both arms and legs. In the seven days before the MDS Assessment she had received 95 minutes of Occupational Therapy and 98 minutes of Physical Therapy. No time was recorded for Restorative Therapy. Record review of Resident #97's care plan initiated 06/27/2024 revealed that her care plan for a self-care deficit with the goal of maintaining or improving her current level of function did not specify which areas of function were to be maintained or improved (such as bed mobility, transfers, or toilet use). The care plan did not specifically address range of motion. The interventions were not personalized to reflect her level of function. One of the interventions to maintain or improve her level of function was evaluation and treatment by PT/OT as per doctor's order. Record review of Resident #97's physician's order dated 05/31/2024 and discontinued 06/07/2024 revealed a PT evaluation was completed 05/31/2024. Physical therapy was recommended five times a week for four weeks to address her deficits by using therapeutic exercise, therapeutic activity, neuromuscular reeducation, manual therapy, and gait training as tolerated to maximize rehabilitation potential. Record review of Resident #97's physician's order dated 06/07/2024 revealed that an OT evaluation was completed 06/07/2024. Occupational therapy was recommended five times a week for four weeks to address her deficits by using therapeutic exercise, therapeutic activity, neuromuscular reeducation, manual therapy, and ADL retraining. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/23/24 at 09:32 AM Resident #97 revealed that the facility was not doing anything such as exercises or therapies to address her range of motion of arms or legs. In an interview on 07/25/24 at 01:58 PM the Director of Rehabilitation revealed that Resident # 97 was discharged from PT and OT on 07/18/2024 because of a change in her payer source. He stated that the resident had not met her goals for PT and had met some of her goals for OT but not all. He said there were people who started therapy and then were discharged before reaching their goals. He said nurses were to monitor residents for decline in their functioning and report changes to therapy. He said that the quarterly MDS assessment might identify decline in resident's function. If nursing or MDS reported a decline a resident's function therapy would do a screen to see if services were warranted. He stated that the facility's restorative program was discontinued about 4 months ago. Under the facility's discontinued restorative program, when residents were discharged from therapy they would be assessed and referred to the restorative program as needed. The goal the restorative program was to maintain the resident's level of functioning. The Director of Rehabilitation said he was not certain if nurses were on top of monitoring residents for changes in functioning. He said MDS had a report they could pull that helped them identify changes in condition. He said that CNA documentation generated reports related to resident functioning that were discussed in staff meetings. In an interview on 07/25/24 at 02:16 PM MDS Nurse K revealed that changes in a resident's level of functioning would be identified by therapy assessment, reports of changes in function from nurses, or CNA's Point of Care documentation. The therapy assessment would be used in combination with the nursing assessment to complete the GG section (Functional Assessment) of the MDS. Big changes in a resident's functioning would be confirmed by interview and observation of the resident. In an interview on 07/25/24 at 03:44 PM the DON revealed the facility had recently discontinued the Restorative Program. She said she did not believe CNAs received training on doing ROM exercises with residents. She said nurses would tell Therapy if a resident had a change in functional status. A change in functional status would be determined by comparing a resident's current function with function at baseline, as recorded in the care plan. If a nurse or CNA noticed a change in a resident this would be reported and the resident would be referred to the therapy for an evaluation. In an interview on 07/25/2024 at 5:14 PM the Administrator revealed that the facility had suspended but not discontinued the Restorative Program. He said that the Therapy team was fully staffed and had meetings to discuss resident's functioning so staff had information regarding changes in long and short term residents. He said that the last time Restorative staff worked was 4/23/2024. In an interview on 07/25/2024 at 3:50 PM with the DON a policy and procedure regarding resident's range of motion or the facility's Restorative Program were requested. The DON stated she did not think the facility had either policy. Neither policies were received prior to exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Resident #23 Accidents 7/5/2024 Fall-Risk Assessment - V 2 Complete Admission 8.0 jlujan110 jlujan110 view print 6/30/2024 Fall-Risk Assessment - V 2 Complete Admission High Risk 12.0 pviado110 pviado110 view print 5/13/2024 Fall-Risk Assessment - V 2 Complete Admission 8.0 letlopez110 letlopez110 view print 4/21/2024 Fall-Risk Assessment - V 2 Complete Other High Risk 10.0 5/13/24 fall: Patient was redirected multiple times by nurse due to her trying to get out of bed multiple times. Nurse went to administer medication to another patient, when [NAME] DON called this nurse and reported patient had fallen. Patient was sitting on floor left arm was in between rail. Patient was assisted to bed by charge nurse and DON. charge nurse assess patient and noted redness to left arm. No other injuries noted at time of assessing. No c/o pain noted or reported. Call Doctor Date Description Status Type Category Score Created By Revised By view print 4/23/2024 Bed Rail Assessment - V 2 Complete Other mholland110 mholland110 view print 10/23/2023 Bed Rail Assessment - V 2 Complete Other jgonzales110 jgonzales110 view print 7/23/2023 Bed Rail Assessment - V 2 Complete Other jgonzales110 jgonzales110 view print 4/22/2023 Bed Rail Assessment - V 2 Complete Other mholland110 mholland110 view print 3/10/2023 Bed Rail Assessment - V 2 Complete Oth 5/15/2024 11:06 Social Service Note Note Text: SW and ADON called the RP of the resident to discuss the potential risk of keeping the mobility rails on. RP was informed of the removal of the rails, and the low bed to be put in place. 34486 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident reviewed for accident hazards/supervision. (Resident #23). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure HA H and NA I demonstrated appropriate transfer techniques while using the mechanical lift for Resident #23. These failures could place residents at risk for injuries. Findings included: Review of Resident #23's Admission Record, dated 7/24/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including paralysis following a stroke. Review of Resident #23's Annual MDS Assessment, dated 4/10/24, revealed: She scored an 8 of 15 on her mental status exam (indicating she was moderately cognitively impaired). She had upper and lower range of motion impairment on one side and used a wheelchair. She was completely dependent on staff for transfers. Active diagnoses included stroke. Review of Resident #23's Care Plan, last revised on 4/15/22, revealed Resident #23 had an ADL Self-care performance deficit related to hemiplegia. The identified goal was Resident #23 would maintain or improve current level of function in ADL score. Identified interventions included assist x 2 for transfers with lift. Observation on 07/23/24 at 3:06 PM, Resident #23 was in bed, she had thin fall mats on either side of her bed. Resident #23 gave permission for a mechanical lift transfer to be watched. NA I stated she had worked at the facility for three days but had worked at another nursing facility where she was trained on how to use a mechanical lift. HA H stated she worked at the facility for 3 months. NA I laid Resident #23 flat in her bed. The aides rolled Resident #23 side to side as they positioned her in the sling. HA H rolled the lift in position by the bed and locked the lift. HA H and NA I had a discussion about which loops to secure the hooks to. The sling was in the wrong place to be secured to the arm of the lift, so HA H and NA I manually slid Resident #23 to the middle of the bed. HA H locked the lift moved the arm to the center of Resident #23 and NA G hooked the sling to the arm of the lift. HA H unlocked the lift and jerked the lift 3 short jerks. When HA H was unable to move the lift over the fall mats, she lifted (wheels left the ground to get over the mat) the lift over the mats manually while Resident #23 was in the air unsecured. Once over the mats, NA G moved the shower chair into place, locked it and positioned Resident #23 into the shower chair. The two completed unhooking Resident #23 from the lift and took the resident into the shower . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/25/24 at 11:52 a.m., the DON stated her expectation for a mechanical lift transfer was to be completed with two people. The DON expected the aide operating the lift to lock the lift, raise the resident, unlock the resident, and while one staff operates the lift the other holds the person. The DON stated the staff were to bring the resident to the chair, lock the lift, lower the resident, unhook the sling, unlock the lift and take the lift away. The DON was informed of the observation including the uneven surface where the aide pulled the lift over the fall mats. The DON said that was unacceptable. The DON stated therapy and the nursing department trained the staff to use the mechanical lift. The DON said monitoring was done randomly by the DON and ADON. The DON said an in-service was completed recently on how to use the mechanical lift. The DON stated the risk to a resident for an improperly done transfer was injury. The DON said hospitality aide could not complete mechanical lift transfers by themselves, she did not explain the difference between a nurse aide and a hospitality aide. Interview on 7/25/24 at 1:55 p.m., PTA G stated to complete a mechanical lift the aides had to grab a machine, put the resident in a sling, lower the crank (arm), clip the sling to the hooks then use the control to lift and locked the lift again while the second person held the wheelchair and maneuvered the resident into position. PTA G said once in position the resident could be unhooked from the lift. PTA G stated the lift's brakes needed to be locked when going up or down with a resident. PTA G said the orientation on how to use the lift was completed by human relations and the nursing department. PTA G said the nursing department would bring the new staff to the therapy department to be trained on how to use the lift. PTA G said the rehabilitation team as a whole would monitor to make sure mechanical transfers were completed correctly. Review of the in-service completed 7/2/24 of the facility's Hydraulic Lift policy, undated, revealed: The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance. The number of staff to provide assistance with the transfer should be determined by the manufacturer recommendations. Goals: 1. The Resident will achieve safe transfer to bed or chair via a mechanical lift device. 2. The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift. Procedure: Avoid any sudden movement, rising, or lowering that may frighten a resident. (NA I did not sign attendance at the in-service) Review of the facility's Nurse Aide Checklist for Mechanical Lift, undated, revealed: Did not address jerking the lift over an uneven surface.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Resident #97 Urinary Catheter or UTI 07/23/24 09:36 AM cath bag in privacy bag resting on fall mat 07/23/24 09:33 AM Interview observation with [NAME] - Cath bag on floor - photo taken. 07/23/24 09:58 AM [NAME], LVN - adjust bed so bag is not on fall mat. States bag is touching because of fall mat, should not be on the floor for infection control reasons. 07/25/24 03:22 PM DON - regarding cath bag o nthe floorit doses have a privacy bag. Doe nto know policy as to wehtehr the bag is sufficient protection. IF the bag is not sufficient protection there is a risk for intection - CNAs asll clinical staff responsible fo thei .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for two (Residents #256 and #38) of 7 residents reviewed for provision of respiratory care. The facility failed to ensure that Resident #256's oxygen concentrator filter was free of accumulations of dust. The facility failed to ensure that Resident #38's oxygen concentrator filter was free of accumulations of dust. This failure put residents at increased risk of inhaling dust and germs. Findings included: Record review of Resident #256's face sheet dated 7/25/2024 revealed [AGE] years old and was admitted to the facility 06/27/2024. Record review of Resident #256's hospital history and physical dated 06/25/2024, revealed she had diagnoses including stroke. She received supplemental oxygen through a nasal cannula (a thin plastic tube) while in the hospital. Record review of Resident # 256's admission MDS dated [DATE] revealed she had a BIMS score of 12 (moderate cognitive impairment). She had diagnoses including stroke and high blood pressure. She was receiving oxygen therapy. Record review of Resident # 256's care plan dated 06/28/2024 revealed she was receiving oxygen therapy. The care plan goal was that she would have no signs or symptoms of poor oxygen absorption. The care plan contained no interventions. Record review of Resident #256's physician's order dated 06/26/2024 and discontinued 07/25/2024 revealed she would receive oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath. Record review of Resident #256's physician's order dated 07/25/2024 revealed she would receive oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath. In observation and interview on 07/23/24 at 09:19 AM Resident #256 was lying in bed. An oxygen cannula on her head with the prongs in her nose. The tubing ran from her bed to an oxygen concentrator by her bed. The oxygen concentrator was heard to be running. Observation of the oxygen filter revealed that it had an accumulation of dust on the inner vanes of the filter and on the vanes of the filter cover. The resident did not remember if staff had cleaned the oxygen filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/23/24 at 09:24 AM LVN E revealed that respiratory therapy was responsible for the care of the oxygen filters, including changing out the tubing and keeping the filter clean. She said residents might inhale dust if the oxygen filters on the concentrators were not kept clean. Record review of Resident #38's face sheet dated 07/24/2024 revealed she was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #38's hospital history and physical dated 05/28/2024 revealed she had diagnoses acute respiratory failure (body is getting enough oxygen), high blood pressure, hypernatremia (high levels of sodium in the blood), dementia, and had a history of a broken left hip. Record review of Resident #38's admission MDS assessment dated [DATE] revealed her BIMS score was 9 (Moderate cognitive impairment. She had diagnoses including respiratory failure and high blood pressure. She was receiving oxygen therapy on admission while a resident. Record review of Resident #38's Admission Nurses Note dated 05/21/2024 revealed she was receiving oxygen via nasal cannula. Record review of Resident #38's care plan dated 05/21/2024 revealed she was receiving oxygen therapy and would not have signs or symptoms of poor oxygen absorption. Record review of Resident #38's physician's order dated 05/21/2024 revealed she was to receive oxygen at 3 liters per minute every shift for shortness of breath. Record review of Resident #38's physician's order dated 05/21/2024 revealed staff were to change or clean the filter of the concentrator machine every night shift every Sunday. Observation on 07/23/2024 at 10:10 AM revealed Resident #38 was lying in bed with an oxygen cannula on her head with the prongs in her nose. The tubing ran from her bed to an oxygen concentrator by her bed. The oxygen concentrator was heard to be running. Observation of the oxygen filter revealed that it had a dense accumulation of dust on the inner vanes of the filter and on the vanes of the filter cover. In an interview on 07/23/24 at 10:22 AM LVN F revealed that the filter had too much gunk or dust on it. He said that respiratory therapists were responsible for the oxygen concentrators. He said the respiratory therapists switched the lines and bubbler but did not know about the filters. He said the risk to residents of dust in the oxygen concentrator filters would be that they might not get enough oxygen. He said the dust put residents at risk for allergies, asthma, and infection. In an interview on 07/25/24 at 03:40 PM the DON revealed that respiratory therapy was responsible for making sure that oxygen machines are functioning properly and should be checking the filters. The risk to residents of a dusty filter included that they might not receive the desired effect of the oxygen. Residents might not get enough oxygen, and there was an increased risk of infection.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 (Residents #210) of 12 residents and for 2 of 5 medication carts reviewed for pharmaceutical services. LVN A did not administer Resident #210's scheduled multivitamin with minerals as indicated by the physician orders. The medication cart used for hall 400 and 500 had insulin pens that had expired as indicated by the manufacturer's instructions. These failures could place residents at risk of not receiving medications as prescribed or the therapeutic benefit of medications or at risk of receiving medications that were expired and not produce the desired effect and under dosed. The findings were: Record review of Resident #210's Admission Record, dated 07/24/2024, indicated she was admitted to the facility on [DATE] with diagnoses of nutritional deficiency and pressure ulcer of buttock. She was [AGE] years of age. Record review of Resident #210's order summary report dated 07/24/2024 indicated in part: Multivitamin-Minerals Oral Tablet (Multiple Vitamins with Minerals) Give 1 tablet by mouth one time a day for supplement. Order status = active. Order date 07/19/24. Start date 07/20/24. During an observation on 07/24/24 at 09:10 AM, LVN A administered Resident # 210's medications. LVN A took a bottle of multi-vitamin without minerals and poured 1 tablet into a medication cup and administered it to the resident. During an interview and observation on 07/24/24 at 01:14 PM, LVN A said she had given Resident #210 the multi-vitamin in the bottle which had the blue label that indicated High potency multivitamin supplement further inspection of the bottle revealed that it did not contain minerals as indicated on the supplement facts label. LVN A said she was aware the resident was ordered to have a multi-vitamin with minerals but was not sure if they had any of the one with minerals. LVN A then went to the medication room to look for vitamin with minerals and in the medication room she found some vitamin with minerals bottles. LVN A then took and placed the bottle in the medication cart. LVN A said that earlier there were no vitamin with minerals bottles in the medication room. LVN A said if Resident #210 did not receive the correct multi-vitamin with minerals, then the resident would not be receiving the minerals as indicated by the doctor's orders . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/24 at 01:09 PM, the DON was made aware of LVN A administering the multi-vitamin without minerals to Resident #210. The DON said the nurse should have followed the physician order as indicated. The DON said if the nurse did not give the multi-vitamin with minerals as indicated then the resident would not receive the desired effect. The DON said the failure occurred because the nurse did not follow the order as indicated and should have reported to her that they were out of the multi-vitamin with minerals so they could have ordered some or gone to the store and bought some. During an interview on 07/25/24 at 01:58 PM, the Administrator was made aware of LVN A administering the multi-vitamin without minerals to Resident #210. The Administrator said the nurse should have followed the physician order and administered the vitamin with minerals as not following the order could lead to the resident not receiving the medication as ordered. The Administrator said the failure occurred because the nurse should have reported to the DON that they did not have the multi-vitamin with minerals so they could have restocked it right away. During observation and interview on 07/24/24 at 09:28 AM, the nurse medication cart for hall 400 was inspected for expired medications with LVN A present. The LVN A unlocked and open the cart and on the top drawer were several insulin pens. One of the insulin pens had an open date of 06/23/2024 inscribed on it and the pen label indicated Use within 28 days after initial use. The LVN A said that 06/23/2024 was the date the pen had been opened. LVN A said it was every nurse's responsibility to remove the expired insulins from the cart. LVN A said this was the cart she had been using today and had not noticed that the insulin pen had already expired. LVN A said if a resident received an expired insulin dose, they might not receive the desired effect. During an interview and observation on 07/25/24 at 10:42 AM, the nurse medication cart for hall 500 was inspected with LVN B present. Inside the top medication drawer was an insulin pen that had the date of 05/25/24 inscribed on it. The LVN B stated that 05/25/24 indicated the insulin pen was open on that date. LVN B said the insulin pens were usually good for 30 days after opening. The LVN B said that it was each nurse's responsibility to monitor the medication cart for expired insulins and to remove them if needed. LVN B said she had not noticed the insulin pen had already expired. LVN B said that if a dose of expired insulin was given to a resident, then that resident might not receive the desired effect. During an interview on 07/25/24 at 01:19 PM, the DON was made aware of the insulin pen observations. The DON said it was expected for the nursing staff to date the insulins when opened. The DON said the insulin pens were good for 28 days after opening them. The DON said they did random audits of the medication carts to check them for expired medications or not dated when opened. The DON said she believed the expired insulins were still in use because the nurses using the medication cart did not dispose of them. The DON said if a resident received a dose of an expired insulin, then the resident might not receive the desired effect. During an interview on 07/25/24 at 02:02 PM, the Administrator was made aware of the expired insulin pen observations. The Administrator said the nurses should have removed the expired insulin pens from the cart. The Administrator said if the nurses used the expired insulins on the residents, then the residents might not receive the desired effect, The Administrator said the failure occurred because the nurses did not remove the expired insulins from the cart and had them replaced. (continued on next page)

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	676342	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Teresa Nursing & Rehab Center	10350 Montana Avenue El Paso, TX 79925

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility document titled Pharmacy policy & procedure manual and dated 2003 indicated in part: Medication administration procedures - all medications are administered by licensed medical or nursing personnel. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered. The 10 rights of medication should always be adhered to 2. Right medication. 3. Right dose. Record review of the facility document titled Pharmacy policy & procedure manual and dated 2003 indicated in part: Recommended medication storage - medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. Insulins (vials, pens) Refrigerate until initial use. Expires 28 days after initial use regardless of product storage.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews and record review the facility failed to ensure that residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for three (Residents #27, #93, and #255) of 5 residents reviewed for unnecessary medications. The facility failed to ensure Resident #27 did not receive Risperidone, an anti-psychotic to treat Delusional disorder. The facility failed to ensure Resident #93 did not receive Aripiprazole, an antipsychotic to treat depression. The facility failed to ensure Resident #255 did not receive Quetiapine, an antipsychotic to treat dementia. These failures could place residents at risk for adverse consequences such as impairment or decline in an individual's mental, physical or psychosocial status from receiving unnecessary antipsychotic medications. Findings included: Resident #27 Record review of Resident #27's face sheet dated 07/25/2024 revealed he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #27's electronic diagnosis listing accessed 07/25/2024 revealed he had diagnosis including Pseudobulbar affect (a neurological condition causing uncontrollable crying or laughing), vascular dementia with behavioral disturbance, unspecified intellectual disabilities, history of traumatic brain injury, and anxiety disorder. Record review of Resident #27's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 99 (unable to complete the BIMS interview). Staff assessed Resident #27 as having short- and long-term memory problems. He had symptoms of delirium including continuous difficulty focusing his attention. He had no indicators of psychosis. He had behaviors including daily behavioral symptoms directed toward others and other behaviors not directed toward others that occurred 4 to 6 days of the week. He rejected care 4 to 6 days during the seven days prior to the assessment. His diagnoses included non-Alzheimer's dementia, anxiety disorder and depression, pseudobulbar affect, and unspecified intellectual disability. In the seven days prior to the assessment, he had received an antipsychotic medication. Record review of Resident #27's care plan last revised 07/27/2023 revealed he required the anti-psychotic medication Risperidone. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's Psychiatric Subsequent assessment dated [DATE] revealed his diagnosis of Delusional disorder is being treated with Risperidone. Record review of Resident #27's physician's order dated 03/15/2024 revealed he was to receive 1 MG of risperidone two times a day for Delusional Disorder. In an interview on 07/25/24 at 03:38 PM the DON revealed she was uncertain if delusional disorder was an appropriate diagnosis for an antipsychotic. Resident #93 Record review of Resident #93's face sheet dated 07/25/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #93's hospital history and physical dated revealed he had diagnoses including diabetes, hypertension (high blood pressure), end-stage renal disease (kidney failure), and was receiving dialysis. Record review of Resident #93's electronic diagnosis record reviewed 07/25/2024 revealed he had diagnoses including Major depressive disorder and dementia. Record review of Resident #93's 5-day MDS assessment dated [DATE] revealed he had a BIMS score of 13 (cognitively intact). He had no symptoms of delirium, depression, or psychosis. He had no symptomatic behaviors. His diagnoses included non-Alzheimer's dementia and depression. During the seven days prior to the assessment he had received antipsychotic medications. Record review of Resident #93's care plan dated revised 07/05/2024 revealed he required anti-psychotic medications. Record review of Resident 93's physician's order dated 06/26/2024 revealed he was to receive 2 MG of Aripiprazole daily to treat depression. In an interview on 07/25/24 at 03:32 PM the DON revealed that prescribing an antipsychotic for depression was not correct. She said that antipsychotics put residents at increased risk of sleepiness and extrapyramidal effects (unwanted movements). Resident #255 Record review of Resident #255's face sheet dated 07/25/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #255's hospital history and physical dated revealed he had diagnoses including depression and altered mental status. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #255's 5-day MDS assessment dated [DATE] revealed he had a BIMS score of 1 (severe cognitive impairment). He had symptoms of delirium including continuous difficulty focusing attention. He had symptoms of mild depression. He had no symptoms of psychosis and no behavioral symptoms. His diagnoses included anxiety and depression. He had received an antipsychotic medication during the seven days prior to the assessment. Record review of Resident #255's care plan dated 07/12/2024 revealed he required an anti-psychotic medications to address dementia. Record review of Resident #255's physician's order dated 07/10/2024 revealed he was to receive 100 MG of Quetiapine (an Antipsychotic medication) daily at bedtime for dementia. In an interview on 07/25/24 at 03:35 PM the DON revealed dementia was not an appropriate diagnosis for Quetiapine. She said when a medication came in with an incorrect indication it was up to the ADON or the DON to call the physician. Record review of the facility policy Psychotropic Drugs revised 10/25/2027 revealed that resident would not be given psychotropic drug unless they were needed to treat a specific condition as diagnosed and documented in the clinical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 FACILITY Medication Administration During an interview and observation on [DATE] at 01:14 PM LVN [NAME] said she had given Resident #210 Ligia Akell the multi vitamin in the bottle which had the blue label that indicated High potency multivitamin supplement further inspection of the bottle revealed that it did not contain minerals as indicated on the supplement facts label. LVN [NAME] said she was aware of the resident ordered to have a multi-vitamin but was not sure if they had any of the one with minerals. LVN [NAME] then went to the medication room to look for vitamin with minerals and in the medication room was found some vitamin with minerals which she then took the place in the medication cart. LVN [NAME] said that earlier there were no vitamin with minerals bottles in the medication room. During an interview on [DATE] at 01:09 PM the DON [NAME] was made aware of the nurse administering the multi-vitamin without minerals to Resident #210. The DON said the nurse should have followed the physician order as indicated. The DON said if the nurse did not give the multi-vitamin with minerals as indicated then the resident would not received the desired effect. The DON said the failure occurred because the nurse did not follow the order as indicated and should have reported to her that they were out of the multi-vitamin with minerals. During an interview on [DATE] at 01:58 PM the Administrator was made aware of the medication error. The Administrator said the nurse should have followed the physician order and administered the vitamin with minerals as not following the order could lead to the resident not receiving the medication as ordered. The Administrator said the failure occurred because the nurse should have reported to the DON that they did not have the multi-vitamin with minerals so they could have restocked it right away. Medication Storage and Labeling [DATE] 09:28 AM inspected nurse medication cart for hall 400 with LVN [NAME] present the cart was locked, nurse unlocked it, checked the the top drawer where there were some insulin pens and vial, one insulin pen had an open date of [DATE] and indicated Use within 28 days after initial use. LVN [NAME] said it was every nurses responsibility to remove the expired insulins from the cart. LVN [NAME] said if a resident received an expired insulin dose they might not receive the desired effect. [DATE] 09:43 AM [NAME] LVN, inspected medication cart with LVN [NAME] present, the cart was locked so the nurse unlocked it - the regular medication drawers were checked no concerns noted next checked the controlled medication drawer which was locked with a second lock so the nurse unlocked it, the controlled medications were accounted for wen reconciled with their matching count sheets, the medication cart used for hall 200. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 10:00 AM Crystal [NAME] LVN, inspected medication cart with LVN [NAME] present, the cart was locked so the nurse unlocked it - the regular medication drawers were checked no concerns noted next checked the controlled medication drawer which was locked with a second lock so the nurse unlocked it, the controlled medications were accounted for wen reconciled with their matching count sheets, the medication cart was for hall 400. [DATE] 11:54 AM inspected medication room with LVN [NAME] present, the room was locked so the nurse unlocked it, the room was well lit, there was a sink/faucet/soap/paper towel dispenser and trash can available, there was a Pyxis medication machine that was used as an ER kit as well, there was a full size refrigerator that contained some medications these medications were insulins, suppositories, TB vials and other meds there was no concerns noted in fridge. There were several OTC meds in the cabinets, there were no concerns noted during this inspection. [DATE] 01:04 PM inspected the DC controlled medications with the DON present, the medications were stored in a medication room, the medications were stored in a cabinet that was affixed to the [NAME] of the cabinets in the room, it was locked with 2 locks so the DON unlocked it, inside were some medications and they were accounted for, no concerns noted. [DATE] 03:12 PM inspected medication cart with CMA [NAME], the cart was locked so the nurse unlocked it - the regular medication drawers were checked no concerns noted, there were no controlled medications kept in this cart which was for hall 500 the CMA said the nurses cart had the controlled medications. There were no issues with this inspection. During an interview and observation on [DATE] at 10:42 AM the nurse medication cart for hall 500 was inspected with LVN [NAME] present. Inside the top medication drawer was an insulin pen that had the date of [DATE]. LVN [NAME] said the insulin pens were usually good for 30 days after opening. The LVN said that it was each nurses responsibility to monitor the medication cart for expired insulins and to remove them if needed. LVN [NAME] said she had not noticed the insulin pen had already expired. LVN [NAME] said that if a a dose of expired insulin was given to a resident that might not receive the desired effect. The rest of the medications were fine then the controlled medications were inspected and found to be accounted for when reconciled with their corresponding med sheets, the cart was locked and also the controlled medication drawer was locked with a second lock, there were no other concerns noted during this inspection. During an interview on [DATE] at 01:19 PM the DON [NAME] was made aware of the insulin pen observations. The DON said it was expected for the nursing staff to date the insulins when opened. The DON said the insulin pens were good for 28 days after opening them. The DON said they did random audits of the medication carts. The DON said she believed the expired insulins were still in use because the nurses using the medication cart did not dispose of them. The DON said if a resident received a a dose of an expired insulin then the resident might not receive the desired effect. During an interview on [DATE] at 02:02 PM the Administrator was made aware of the expired insulin pen observations. The Administrator said the nurses should have removed the expired insulin pens from the cart. The Administrator said if the nurses used the expired insulins on the residents then the residents might not receive the desired effect, The Administrator said the failure occurred because the nurses did not remove the expired insulins from the cart and had them replaced.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interviews, and record reviews, the facility failed maintain medical records on each resident that were accurately documented for 3 of 12 residents reviewed for medical record accuracy. (Resident #97, #155 and #259) - The facility failed to ensure that Resident #97's a Texas Out of Hospital DNR was completed prior to documenting in the resident's chart that she had a DNR status - The facility failed to ensure Resident #155 who was listed as DNR (Do Not Resuscitate) had an Out-of-Hospital Do Not Resuscitate (OOH-DNR) form. - The facility failed to ensure that Resident #259's Texas Out of Hospital DNR had been signed by a physician prior to documenting in the resident's chart that she had a DNR status This deficient practice could place residents at risk of having their end of life wishes dishonored, and of having cardiopulmonary resuscitation (CPR) performed against their wishes. Findings included: Resident #97 Record review of Resident # 97's face sheet dated [DATE] documented she was [AGE] years old was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #97's 5-day MDS dated [DATE] revealed she had a BIMS score of 8 (Moderate Cognitive impairment). She had diagnoses including chronic obstructive pulmonary disease (lung condition that causes breathing problems) , and metabolic encephalopathy (Brain disorder caused by chemical imbalance in the blood). Record review of Resident #97's care plan initiated [DATE] revealed she had an order for Do Not Resuscitate, and that in the absence of blood pressure, pulse, respiration, CPR would not be initiated. Record review of Resident #97's electronic diagnosis listing reviewed [DATE] revealed a heading at the top of the page indicating she had a DNR status. Record review of Resident #97's physician's order dated [DATE] revealed she had a DNR status. Record review of Resident #97's miscellaneous documents revealed no Texas OOH DNR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 02:44 PM the Social Worker revealed that Resident #97's family member had requested that a Texas OOH DNR order be initiated for the resident and had signed a DNR Request. The Social Worker said she had initiated a Texas OOH DNR and that the document was currently pending the physician's signature. She said it was the facility policy to honor resident and family wishes, and that the family member's signature on the DNR request was considered a valid do not resuscitate document while the resident was in the facility, so when the DNR Request was signed, the resident's code status was changed to DNR. She was not sure what the risk might be to the resident of not having a completed Texas OOH DNR. Resident #155 Review of Resident #155 Admission Record, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hip fracture and hypertension. Resident #155's Admission MDS was still in progress. Review of Resident #155's Order Summary revealed order dated [DATE] that she was a DNR. Review of Resident #155's Care Plan, initiated [DATE], revealed she had an order for Do No Resuscitate. The identified goal was Resident or her Responsible Party decision for DNR would be honored through the review date. Identified goals included: All aspects of DNR would be explained to resident or responsible party. In absence of blood pressure, pulse, respiration Cardio-pulmonary resuscitation would not be initiated. Review of the form Request for Do Not Resuscitate documented the request for the DNR was made verbally by a resident who is competent. It was signed by two witnesses on [DATE]. The form documented the attending physician was informed of the requested on [DATE] and included it on the orders on [DATE]. It was signed by Nurse Practitioner on [DATE]. Interview on [DATE] at 11:25 a.m. LVN B stated that the OOH-DNR was supposed to be in the resident documents in the electronic files. LVN B stated Resident #155's electronic heading showed she was a DNR as did her orders so she would treat Resident #155 as a DNR. LVN B looked in Resident #155's electronic files and saw the Request for Do Not Resuscitate. LVN B stated the Request was not an OOH-DNR and she would need the actual form for the DNR to be valid. LVN B said the nurse doing the admission was responsible for getting all the proper documentation on admission but the social worker was responsible for completing the OOH-DNR. Resident #259 Record review of Resident #259's face sheet dated [DATE] revealed she was [AGE] years old and was admitted to the facility [DATE]. Record review of Resident #259's quarterly MDS dated [DATE] revealed she had a BIMS of 14 (cognitively intact). She had diagnoses including respiratory failure. Record review of Resident #259's care plan dated [DATE] revealed she had an order for Do Not Resuscitate, and that in the absence of blood pressure, pulse, respiration, CPR would not be initiated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #259's electronic diagnosis listing reviewed [DATE] revealed a heading at the top of the page indicating she had a DNR status. Her diagnoses included a fracture of the upper end of the left humerus (broken left arm), emphysema, and pulmonary fibrosis. Record review of Resident #259's physician's order dated [DATE] revealed a physician's do not resuscitate order. Record review of Resident #259's Texas OOH DNR document dated [DATE] revealed it did not have a physician's signature. In an interview on [DATE] at 02:44PM the Social Worker revealed that because Resident #259's Texas OOH DNR was not signed by a physician, the OOH DNR was not valid. She stated she had reviewed Resident #259's Texas OOH DNR but had not noticed that it was not signed by the physician. She said she had left the document for the physician's signature, but it appeared that medical records took it and scanned it before the physician could sign it. She said the family had signed the facility's DNR Request so was not sure what the risk might be to the resident of not having a completed Texas OOH DNR. Interview on [DATE] at 11:52 a.m. the DON said if a resident requested to be DNR status the facility would initiate the DNR Request assessment and change them to the DNR status. The DON said the Social Worker was responsible for getting the OOH-DNR form signed. The DON confirmed the staff would treat the resident like they were a DNR once they signed the Request for DNR even though they had not signed the OOH-DNR. The DON said she thought that was the facility policy and that was what they trained the nurses to follow. Interview on [DATE] at 2:07 p.m. the Social Worker stated she the DNR was usually obtained within the first 72 hours the staff would get the request for the DNR in the assessment tab and it would get filled out. The Social Worker stated it would usually be her but sometimes it would be nursing. The Social Worker said after the form was filled out, they notify the physician, get the order, update the care plan, and put it in the electronic record. The Social Worker said it was considered a DNR at the point when the request form was signed, and the care plan was updated, and the nurses put in the order. Record review of the facility policy Advance Directives Policy and Record dated [DATE] revealed that the facility recognized and implemented the resident' rights under state law to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives. The facility agreed to honor decisions concerning medical care when made in accordance with state laws, and valid Advance Directives made in accordance with state law. If the resident had an invalid advance directive and the resident or representative wished to refuse, withhold or withdraw life sustaining medical treatment, such decision would be made consistent with state law. Full consideration would be given to the applicable state law as interpreted by the Legal Department.

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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** 26221 Resident #4 Urinary Catheter or UTI Resident #23 Urinary Catheter or UTI Resident #33 Urinary Catheter or UTI 34486 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 4 of 5 residents (Residents #4, #33, #73, and #155) reviewed for infection control. The facility failed to ensure airborne precautions were followed for Resident #155 who had Shingles. The facility instructed staff to follow contact precautions. The facility failed to ensure Residents #4, #33, and #73's urinary catheters were not on floor. This failure could affect residents by placing them at an increased risk of exposure to communicable diseases and infections. The findings included: Resident #155 Review of Resident #155 Admission Record, dated 7/24/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including hip fracture and hypertension. Resident #155's Admission MDS was still in progress. Review of Resident #155's Order Summary revealed order dated 7/16/24 of Contact Isolation Precautions due to Shingles, all services rendered in room: therapy, medications, meals and ADLs, every shift. (continued on next page)

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	676342	A. Building B. Wing	07/25/2024

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #155's Care Plan, initiated 7/24/24, revealed Resident #155 had a Skin Soft Tissue infection (Shingles). The goal was Resident would be free from complications related to infection through the review date. Identified interventions included: maintain universal precautions when providing resident care; monitor for increased signs of infection; swelling, drainage, redness, pain, warmth. Observation and interview on 7/23/24 at 9:56 a.m. revealed Contact Precautions sign posted at her door with a container of gowns and gloves. The sign instructed enterers to clean hands when entering and leaving the room as well as gown and glove. At that time the ADON stated Resident #155 had Shingles. There were no masks in the PPE cart. Observation on 7/24/24 at 2:27 p.m. revealed staff donning PPE to go into Resident #155's room. They donned gown and gloves, but no mask and entered the room. Observation on 7/25/24 at 11:14 a.m. revealed therapy going into Resident #155's room. The therapists donned gowns and gloves but no masks. Interview on 7/25/24 at 11:52 a.m. the DON stated the type of isolation the resident needed depended on the source of the infection. She said at the moment all they had was contact isolation which needed gowns and gloves. The DON stated they got orders from the doctor and put out bins and posted signs outside people's rooms to let people know what kind of precautions they needed to take and if the person did not know they could go to the nurse's station and stop and ask. The DON was asked to look up the precautions needed for Shingles, and she said it was standard precautions plus airborne and contact. The DON said that meant people needed to wear gown, gloves, and mask. The DON said Resident #155 was on Contact Precautions which according to what she looked up was not correct. The DON said the risk to the residents was the Shingles virus could spread. The DON said she was not sure if the facility offered the shingles vaccine to the residents. The DON said the Shingles vaccine was not offered to the staff. The DON said she and the ADON monitored to see if staff were following PPE recommendations related to isolation procedures and she did those checks randomly when she did rounds. Interview on 7/25/24 at 1:55 p.m. PTA G said residents on isolation had services provided in-room. PTA G stated there was a flier outside of the room saying what kind of isolation the resident had, and the therapy department could check with the nurse's station about what condition the resident had. PTA G stated Resident #155 had shingles on her chest and was on contact precautions which required gown and gloves and hand washing after doffing PPE. PTA G stated Shingles was usually contact precautions like chicken pox. Record review of Preventing Varicella-Zoster Virus (VZV) Transmission from Herpes Zoster (shingles) Preventing VZT Transmission in Healthcare Settings from the Centers of Disease Control and Prevention website https://www.cdc.gov/shingles/hcp/infection-control/index.html revealed: Infection control measures depend on whether the patient with herpes zoster is immunocompetent or immunocompromised. Healthcare professionals should also determine if the rash is localized or disseminated (appearance of lesions outside the primary or adjacent dermatomes). The type of isolation precautions recommended were Airborne and contact precautions until lesions are dry and scabbed. Resident #4 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's Admission Record, dated 7/25/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a readmitted d of 7/16/24, with diagnoses which included stroke and neuromuscular dysfunction of the bladder. Review of Resident #4's Admission MDS Assessment, dated 4/24/24, revealed: She had long and short-term memory impairment with severely impaired cognitive skills. She showed signs of delirium including inattention which was continuously present. She was completely dependent on staff for all ADLs. She had an indwelling catheter. Active diagnoses included stroke and neurogenic bladder. Review of Resident #4's Care Plan, revised 2/16/24, revealed: Resident #4 had an indwelling foley catheter. The identified goal was Resident will show no signs or symptoms of urinary infection through review date. Identified interventions included: Check tubing for kinks and maintain the drainage bag off the floor. Review of Resident #4's Order Summary, dated 7/25/24, revealed orders: 6/19/24 Urinary Catheter 16 French/10 cc to gravity drainage every shift related to Neuromuscular Dysfunction of Bladder 6/19/24 Ensure foley bag is in privacy bag while in bed or wheelchair every shift related to Neuromuscular Dysfunction of Bladder. Observation on 7/23/24 at 11:43 a.m. revealed Resident #4 in bed, the bed was in the lowest position and the catheter was hooked to the bed dragging on the floor. Observation on 7/25/24 at 11:19 a.m. revealed Resident #4 in bed with her catheter tubing on the floor. Interview and observation on 7/25/24 at 11:25 a.m. LVN B stated catheters needed to be hooked onto the bed and put into a privacy bag. LVN B said the nurses needed to make sure the catheters needed to stay clean at all times by keeping the catheter line and bag off the floor. LVN B was taken into Resident #4's room and said Resident #4's catheter tubing was on the ground. LVN B stated keeping the catheters in bags and off the ground was delegated to the CNA's but the nurses were also responsible for monitoring it. LVN B said, it's not hard, it's just not being done. Resident #33 Review of Resident #33's Admission Record, dated 7/24/24, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of the bladder. Review of Resident #33's Quarterly MDS Assessment, dated 4/16/24, revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She scored a 5 of 15 on her mental status exam (indicating severe cognitive impairment) She was totally dependent on staff for all ADLs except eating and oral hygiene. She had an indwelling catheter. Active diagnosis included neurogenic bladder. Review of Resident #33's Care Plan, updated 7/16/23, revealed Resident #33 had an indwelling catheter: neurogenic bladder. Identified goals included Resident #33 would show no signs or symptoms of urinary infection through the review date. Identified interventions included: check tubing for [NAME] and maintain the drainage bag off the floor and in a privacy bag to maintain dignity. Review of Resident #33's Order Summary Report, dated 7/24/24, revealed orders: 5/14/24 Ensure foley bag is in privacy bag while in bed or wheelchair every shift related to Neuromuscular dysfunction of bladder. Observation on 7/23/24 at 2:38 p.m. revealed Resident #33 in bed she had her catheter wrapped in a pillowcase with the catheter/pillowcase on the floor. Interview on 7/25/24 at 2:45 p.m. the DON stated the expectation for catheters was for them not to be on the floor and to be in privacy bags. The DON said all nursing staff - CNAs, nurses, ADON, and DON - were responsible for monitoring that the catheters were in bags and not on the floor. The DON said they randomly checked to see that the catheters were cared for, and they were constantly telling aides to keep them off the floor. The DON stated the facility had approximately 35 catheters and last month approximately 6 had a UTI. She agreed that was around 20% of residents with a catheter had a UTI and could see why surveyors would be concerned about catheters on the floor. Resident #73 Review of Resident #73's Admission Record, dated 7/25/24, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including retention of urine, unspecified with Urinary Tract Infection. Review of Resident #73's Quarterly MDS Assessment, dated 12/12/24, revealed a BIMS (Brief Interview of Mental Status of 15 indicating he was cognitively intact. He required staff to prompt him for all ADLs. He had an indwelling catheter. Review of Resident #73's Care Plan, updated 05/09/22, revealed Resident #33 had an indwelling foley catheter with history of obstructive uropathy (blockage in your urinary tract.) During an observation on 07/23/24 at 2:39 PM, Resident # 73 was laying on his bed to his right side and his foley bag was directly on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/24 10:05 AM, LVN J revealed she had known Resident # 73 for about a year. LVN J said the procedure to make sure he does not suffer from infections or discomfort, CNAs, LVNs and RNs need to check on all the residents who have a catheter. LVN J stated that for Resident # 73 staff needed to make sure the foley was draining into the bag, that the foley was secured to the leg strap; to assure the bag did not have holes or leakage and to make sure the bag is not touching the floor. LVN J watched the picture of Resident # 73 with the foley bag on the floor and stated the bag had to be secured to the bed rail and not on the floor. LVN J said that by the bag being on the floor, there was a potential of infection control. She said there was also a possibility of someone stepping on the foley bag which could cause injury or discomfort to the resident. During an interview on 07/25/24 10:016 AM, LVN B revealed RNs, CNAs, LVNs and DON are responsible for checking on all the residents who have foley bags throughout their shift. Upon observation from the picture of Resident # 73, LVN B said his bag needed to be secured to the rails of his bed and not on the floor and the potential outcomes of the bag being on the floor could result in infection or a urinary tract infection for the resident. LVN B said someone could step on the bag spilling its contents which could contaminate the room. LVN B said another risk could be that Resident #73 could get injured because of someone stepping on the foley bag which could cause pain and irritation. During an interview on 07/25/24 10:28 AM, the DON revealed the foley bag needs to be below the bladder so it can properly drain. The DON said the bag should not be on the floor because it was a risk for infection to Resident # 73 as well as to the floor and the room. The DON said there was a risk of Resident # 73, his roommate or anyone who walked into the room to step on the bag spilling its contents. The DON said another risk was that he could be injured or feel irritated where the foley is connected. Record review of the facilities' policy dated 2003 labeled Catheter Care stated in part: check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. Be sure the catheter tubing and drainage bag are kept off the floor. 49854 Resident #73 Urinary Catheter or UTI 07/23/24 03:27 PM 07/23/24 02:39 PM catheter bag on the floor. Resident was laying on his bed at this time. Said the only complain he had was that they need to update the menu because they don't change it and they always eat the same things, such as eggs. No other complaints and said staff treats him very well.