

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER St. Teresa Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10350 Montana Avenue El Paso, TX 79925	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 3 of 12 residents (Residents #84, Resident #88 and #67) reviewed for call lights. This failure placed residents at risk of having their needs unmet when they are unable to contact staff. Findings included: Resident # 84. Record review of Resident #84's admission record dated 9/14/25, revealed he was admitted on [DATE]. Record review of Resident #84's health and physical dated 5/28/25, revealed he was an [AGE] year-old male with diagnoses of unspecified dementia, acute kidney failure, benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs in older men a non-cancerous enlargement of the prostate gland that commonly occurs in older men) with lower urinary tract symptoms, dysphagia (difficulty swallowing) and repeated falls. Record review of Resident #84's quarterly MDS dated [DATE] revealed the resident had a BIMS of 9 which means he was moderately cognitively impaired. The MDS revealed under section GG for functional abilities the resident required assistance, meaning verbal cues, touching or steadying, with toileting hygiene, showering upper and lower dressing, and moderate assistance, meaning the staff helps the resident by lifting, holding or supporting trunk or limbs, with sitting to standing position, transfers from bed to chair and toilet transferring. The MDS indicated under section H for bladder and bowel that Resident # 84 was frequently incontinent from urinary and bowel continence. Record review of Resident #84's care plan dated 06/10/25 revealed the resident had an ADL self-care performance deficit and was a fall risk related to impaired mobility, muscle weakness, dementia and history of falls. The care plan called for interventions to encourage the resident to use the call light to ask for assistance by having the call light within reach at all times. In an observation on 09/14/2025 at 9:56 AM in Resident # 84's room, the resident was asleep on his bed. The bed was in the lowest position, and his call light was in between the bed rails and the mattress at the feet of the bed. The call light was not within Resident #84's reach. In an observation on 09/16/2025 at 9:56 AM in Resident # 84's room, the resident was asleep on his bed. The call light was on the floor in between the resident's bed and the wall. The resident woke up and smiled. An interview was attempted but the resident only nodded and smiled and was not able to answer questions. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/16/2025 at 10:21 AM with the Administrator he stated the purpose of the call lights was for the residents to request assistance if they need help with anything and stated that all staff are constantly being in-serviced and reminded to check for call light placement. The Administrator said that either him or the DON where responsible for training staff. He stated it was unacceptable for the pad to be out of the resident's reach, and the call light should always be within reach of every resident. The Administrator said the potential outcome of not having call lights within reach could result in the resident not receiving help or assistance in a timely manner from the staff. The Administrator stated the facility did not have a specific policy regarding call lights or call placement. In an interview on 09/16/2025 at 10:49 AM with the DON, he stated the purpose of the call lights was for residents to call for assistance from staff whenever they needed help. The DON said the call lights needed to be within reach and accessible for the resident, so they had easy access to call for help. The DON stated if the resident couldn't reach the call light, there was a risk for the resident to injure themselves or have an accident if they tried to get up from bed and they had unsteady balance or were at fall risk. The DON said it was not acceptable for the call light to be in between the bed rails and the mattress of the bed because it was out of reach, and the resident would not be able to call for help if needed. The DON stated that he and the Administrator were responsible for training staff regarding call lights placement upon hiring and whenever there is an incident reported. Resident # 88. Record review of Resident # 88's admission record dated 09/17/2025 reveals the resident was admitted to the facility on [DATE]. Record review of Resident # 88's health and physical dated on 04/26/2022, revealed the resident is currently an [AGE] year-old male with diagnoses of Advanced osteoarthritis (significant joint degeneration), impaired brain functions due to body's metabolism, severe physical weakness, general weakness, and unable to ambulate. As per physical history, Resident #88 previously suffered a femur fracture, chronic back pain, and abnormal gait prior to admission. Record review of Resident # 88's quarterly MDS dated [DATE] revealed the Resident had a BIMS of 14 which means he had intact cognitive functioning. The resident required partial/moderate assistance to substantial/maximal assistance for tasks including self-care and mobility as per "Section GG-Functional Abilities". Additionally, "Section H - Bladder and Bowel" was checked off for indwelling catheter requiring monitoring for the integrity of foley bag, line, and comfort. Record review of Resident # 88's care plan dated 07/18/2025 revealed the Resident has an ADL self-care deficit and required assistance from "x1 staff" for bathing, bed mobility, dressing, toilet use, transferring, and oral hygiene. Resident #67. Record review of Resident # 67's admission record dated 09/17/2025 revealed the resident was admitted to the facility on [DATE]. Record review of Resident # 67's health and physical dated on 08/05/2025, revealed the resident was currently an [AGE] year-old male with diagnoses of dementia (impaired memory, thought process, and (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication), hypothyroidism (a hormonal gland that is not meeting the body's needs), behavioral disturbances (verbal and physical combative tendencies towards others), anxiety (excessive worry and restless do to experienced anguish), and GERD (gastro reflux that causes food and bile back into the esophagus). Record review of Resident # 67 shows the resident had significant change in status MDS (completed 08/14/2025) revealed the resident had a BIMS score of 99 with the significance of this being the resident was unable to participate and complete a brief interview of mental status. As per record review, Resident # 67 required partial/moderate assistance to substantial/maximal assistance for tasks including self-care and mobility as per "Section GG-Functional Abilities. Record review of Resident # 67'S care plan dated 07/17/2025 revealed the resident has potential for altered respiratory status, ADL self-care performance deficit, and impaired cognitive function, refuses treatment and diagnosis of dementia. Resident # 67 was non-ambulatory, on hospice, experienced cognitive impairments, and displayed verbal and physical aggression towards others requiring additional dependence on staff for care. In an observation and interview on 09/14/2025 at 11:38 AM in Resident #88's room, the resident was assisted into his room by staff and remained in his wheelchair. It was observed the resident's call light was excessively wrapped on the right side of his bed rail nearest his roommate's side, placing it out of reach for Resident #88. Resident # 88 reported that the call light was out of reach for him due to him being in his wheelchair and there being no space on the other side to maneuver around. Resident # 88 stated he did not coil his call light on the bed rail. Resident # 88 reported his average wait time for assistance after utilizing the call light was approximately 30 minutes. In an observation on 09/15/2025 at 09:33 AM Resident #67 had just received patient care from CNA A. CNA A proceeded to leave the resident's room while the call pad was out of reach on the floor to the right side of the bed. Resident # 67 was non-interviewable and declined communication with surveyor. In an interview on 09/15/2025 at 11:36 AM with CNA A reported call lights were supposed to be within reach for residents to communicate needs with staff. CNA A reported Resident # 67 was known for throwing stuff off his bed and that she was only leaving the room for a little to get assistance. CNA A believed the call pad for Resident # 67 was within reach and denied any potential negative outcomes for Resident # 67. CNA A stated nurses and CNAs were responsible for repositioning call lights. CNA A reported the last in-service/training she received for call lights was last week. In an interview on 09/15/2025 at 11:55 AM with RN B stated the call light must be within reach of the extension of the arm for residents. RN B reported that everybody who is an employee of the facility is responsible for ensuring that call lights are always within reach. RN B was provided observed scenarios and photo of placement of call devices and reports neither are appropriate conditions for resident's call lights. RN B reported potential outcomes for residents without access to call lights could be the resident is having an emergency, need of help, could fall trying to reach it, or won't receive care. RN B reported that when staff leave the room, they are to always ensure the call light is within reach even if they are coming back promptly. In an interview on 09/16/2025 at 12:02 PM with LVN C, she stated the purpose of the call light is for residents to request service and confirms call lights must be within reach of the resident. LVN C was provided the observed scenarios and photo of placement of call devices for residents and reports neither are appropriate conditions for resident's call lights. LVN C stated call lights should always be (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioned if the call light is out of reach before a staff member leaves the room. LVN C reported that even if residents are known for throwing items off their bed, staff still must ensure the call light is within reach. LVN C was unable to recite last in-service/training received for call lights		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen.-The facility failed to maintain a one-gallon bottle of sweet and sour sauce free from dried drippings in the pantry on 09/14/2025.-The facility failed to maintain a one-gallon bottle of mustard free from dried drippings inside of the walk-in refrigerator on 09/14/2025. These failures could place all residents who received meals from the main kitchen at risk of food borne illnesses. Findings included: During observations on 09/14/2025 that started at 8:10 AM in the kitchen, a couple of bottles with dry drippings were discovered. At 8:26 AM in the dry storage area, a one-gallon bottle of sweet and sour sauce was found on the top shelf with dried drips that ran from its cap all the way down to the bottom. At 8:32 AM, a one-gallon bottle of mustard was found at the top shelf inside the walk-in refrigerator. It was also spotted with dried, smeared drippings of mustard on it. In an interview on 09/16/2025 at 10:21 AM with the Administrator, he explained the importance of container cleanliness in the kitchen and refrigerators. The Administrator stated the dry drippings on the one-gallon mustard bottle could potentially drip down and contaminate other meals, rendering them unsanitary. The Administrator noted the drippings on the one-gallon sweet and sour sauce bottle in the pantry could attract insects and pests, which would introduce a risk of infection if they got into other foods. The Administrator emphasized the serious outcome to the residents which could become sick to their stomach if they consumed any of the contaminated food. In an interview on 09/16/2025 at 10:55 AM with the Dietary Staff, she explained that part of the kitchen staff duties was to clean bottles and keep them free of dry drippings and food particles to prevent the growth of bacteria. The Dietary Staff stated that bottles with dry drippings were a source of contamination that could fall onto fresh food. She stated that the sweet and sour sauce and the mustard bottle with dry drippings were unacceptable, as they could cultivate mold and bacteria that would ultimately make residents sick. She said the drippings could attract pests or insects which could contaminate other foods. The Dietary Staff stated that the potential negative outcome for the residents was that they could get upset stomachs or even food poisoning. In an interview on 09/16/2025 at 11:01 AM with the Dietary Manager, he stated that bottles with dry drippings did not look good, and they were dirty. The Dietary manager stated the bottles needed to be cleaned since they were stored with other bottles in the pantry and inside the walk-in refrigerator and if the bottles were left dirty, sauces like the sweet and sour one-gallon bottle could attract pests and bugs, which might contaminate other food in storage. The manager noted that the mustard bottle was especially messy and could spread bacteria or fungus, leading to contamination of fresh food. The Dietary Manager explained this could cause residents, who often had weak immune systems, to get sick from their stomach or make their condition worse. Record review of the facility's policy dated 2012, titled Food Storage and Supplies, read in part: Food Storage and Supplies. All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Containers are cleaned regularly.		

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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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for two residents (Residents #1, and #4) of twelve residents reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident # 1 to address resident's Tracheostomy care. The facility failed to have a comprehensive person-centered care plan for Resident #4 to address resident's psychotropic medication prescriptions, Trazadone and Buspirone. These failures could affect residents and put them at risk for not receiving care and services to meet their needs. Findings Include: Resident #1 Record review of Resident #1's admission record dated 09/17/2025 revealed a [AGE] year-old male with an admission date of 08/21/2025. Review of Resident #1's history and physical dated 08/13/2025 revealed a diagnosis of tracheostomy (surgical process that creates an opening in the windpipe through the front of the neck providing an artificial airway for breathing) status. Review of Resident #1 's admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Section O- special treatments, procedures and programs revealed tracheostomy care on admission and while a resident. Review of Resident #1 's Care Plan revised 08/04/2025 revealed no information relating to tracheostomy care. In an interview on 09/17/25 at 9:55 AM with the MDS Nurse revealed care plans were personalized to resident needs. She stated care plans assisted the care team on how to approach and assist the resident. She stated baseline care plans were completed upon admission, and the MDS nursing team updated the care plan quarterly. She stated the ADONs assisted with acute care plans which is was done as needed. She stated psychotropic medications should be care planned to monitor for side effects. She also stated the Resident #1's Tracheostomy should have been included in the care plan for staff to provide Tracheostomy care. She stated the risks of not care planning relevant resident information would include staff being unaware of the interventions needed for the resident. In an Interview on 09/17/2025 at 11:10 am with DON revealed that care plans were used to show the most updated plan of care for a resident. He stated that care plans were updated as the resident's care progressed. He stated that care plans needed to be correct on admission to ensure residents were receiving patient centered care. He stated that baseline care plans were created on admission by admitting nurses, DON or ADON. He stated that an acute care plan update would be done by the nurses caring for the resident, and the MDS nurses would update any chronic diagnosis. The risk of not having an updated care plan would be that residents may potentially not receive personalized care. In an interview on 09/17/25 at 01:15 PM with the Administrator, he stated care plans were the plan of care for residents. He stated nursing was responsible for care plans and care plans were reviewed quarterly. He stated the risks for residents not having their care needs in the care plan included for staff being unable to provide accurate care. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Nursing Policy & Procedure Manual policy, Comprehensive Care Planning, with no date, read in part: "Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs." It also read in part: The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident in response to current interventions." Resident #4 Record review of Resident #4's face sheet dated 09/17/25 revealed a [AGE] year-old female with an admission date of 08/04/25. Record review of Resident #4's history and physical dated 06/30/25 revealed medical history of Guillan-Barre (a condition in which the body's immune system attacks the nerves and can cause weakness, numbness or paralysis), Diabetes Mellitus Type 2 (a chronic condition that causes the body to be insulin resistant and causes blood sugar buildup which can affect other systems of the body over time), and hypothyroidism (the thyroid does not produce enough thyroid hormone causing a slowed metabolism). Record review of Resident #4's Nursing home Prospective Payment Systems-Medicare MDS dated [DATE] revealed a BIMS score of 13, indicating resident was cognitively intact. Record review of Resident #4's order summary report dated 09/16/25 revealed resident was prescribed Trazadone HCl Oral Tablet 150 MG at bedtime for sleep on 08/04/25, and Buspirone HCl Oral Tablet 5 MG every 12 hours as needed for Anxiety on 09/04/25. Record review of care plan with revision date 08/05/25 revealed the care plan did not address resident's psychotropic medication prescription.		

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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** Based on observation, interview and record review, the facility failed to provide ADL care for 1 of 16 residents (Resident # 99) reviewed for ADLs. The facility failed to ensure Resident #108's nails were clean and trimmed. This failure could place residents at risk of not having their personal hygiene needs met and cause low self-esteem. Record review of Resident #108's face sheet dated 09/16/25 revealed a [AGE] year-old female with an admission date 05/06/25 and re-admission date 09/09/25. Record review of Resident #108's quarterly MDS dated [DATE] revealed BIMS was not completed since resident was rarely or never understood. Quarterly MDS revealed Resident #108 was Dependent for personal hygiene, meaning the helper does all the effort while the resident does none of the effort to complete the activity. Record review of Resident #108's health and physical dated 05/12/25 revealed a medical history of Acute Ischemic Stroke (the blood supply to part of the brain is blocked or reduced which prevents brain tissue from getting oxygen and nutrients), Pneumonia (an infection of the lungs that causes coughing, wheezing, fever and chills), and Diabetes Mellitus Type 2 (a chronic condition that causes the body to be insulin resistant and causes blood sugar buildup which can affect other systems of the body over time). Record review of Resident #108's care plan with revision date 08/13/25 revealed resident was Hemiplegic affecting her right side (a condition causing paralysis on one side which can be caused by brain injury or damage) and noted interventions for staff to assist resident with ADLs as needed. In an observation on 09/14/25 at 09:50 AM, Resident #108 had 1 inch long and untrimmed fingernails on both hands. Observation of black debris underneath fingernails on both hands including the left thumb and right pointing finger. In an interview on 09/16/25 at 1:38 PM with LVN F, he stated nursing staff were responsible for resident's nail care. He stated the CNA's would provide nail care during the resident's showers which was done three times a week. He stated nurses were responsible for resident's' hygiene such as fingernails and nurses would assess their residents daily. LVN F stated the risks for residents having long and dirty fingernails included residents scratching themselves causing injury and possible infection control due to bacteria under fingernails. In an interview on 09/17/25 at 11:36 AM with the DON, he stated nursing staff provided nail care services such as cutting and cleaning underneath the nail if residents were not diabetic. He stated diabetic residents are assessed and treated by nurses only. He stated nursing staff were to assess residents throughout their shift. The DON stated there was an assigned PRN CNA that assessed resident nails every 2 weeks to monitor and care for as needed. He stated the risks for residents having long untrimmed fingernails included an infection control issue. In an interview on 09/17/25 at 11:36 AM with CNA G, she stated nursing staff trimmed and cleaned resident nails during showers. She stated residents shower three times a week. She stated there was also a CNA that monitored resident fingernails on the weekend. CNA G stated nurses also assessed their residents during their shift. She stated the risks of residents with dirty untrimmed fingernails included possible cuts of skin and infection control issue. In an interview on 09/17/25 at 1:27 PM with the Administrator, he stated nursing staff were responsible for nail care. He stated CNA's file and clean fingernails, but he was unsure how often. He stated it was not sanitary for residents to have untrimmed and dirty fingernails. He stated the ADON's and the DON were responsible for monitoring residents and ensuring nursing staff was providing this service. Record review of facility's Nursing Policy & Procedure Manual, titled Nail Care, with no date, read in part: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails. and Goals: 1. Nail care will be performed regularly and safely.		

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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** Based on observation, interview and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as was possible for 2 of 5 residents (Resident # 110 and # 113) reviewed for accidents. The facility failed to properly recover and dispose of a shaving razor left inside the shared bathroom for Resident # 110 and # 113. The deficient practice could place residents at risk of harm and injury and contribute to avoidable accidents. The findings include: Resident #110. Record Review of Resident #110's face sheet date 09/17/2025 revealed an [AGE] year-old male that was initially admitted to the facility on [DATE]. Record Review of Resident #110's quarterly MDS dated [DATE] revealed the resident has a BIMS score of 09 which means he is moderately cognitively impaired. Record Review of Resident #110's physical and history dated 07/16/2021 revealed the resident was diagnosed with Non-ST Segment Elevation Myocardial Infarction (NSTEMI), which is a type of heart attack; Hypertensive heart disease, which is defined as a condition of prolonged high blood pressure that damages heart tissue; and Diabetes type 2 with hyperglycemia, a condition involving a person experiencing elevated blood sugar levels. Record Review of Resident #110's care plan dated 07/16/2025 revealed that the resident was prescribed Aspirin 81mg as an antiplatelet dated 7/23/2021 under orders, which could increase the risk of bleeding. As per Resident #110's care plan, bathing required supervision, personal hygiene was coded assist as needed, and bed mobility was coded assistance from one staff member. Resident #113. Record Review of Resident #113's face sheet date 09/17/2025 revealed an [AGE] year-old male with an original admission date on 07/15/2017 and a readmission date on 06/29/2023. Record Review of Resident #113's physical and history dated 08/05/2025 of a stroke affecting right dominant side, hemiplegia or a one-sided paralysis and hemiparesis, a neurological condition causing weakness on one side of the body, and type 2 diabetes with nerve damage due to high blood sugar levels. Record Review of Resident #113's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 08 which meant he was moderately cognitively impaired. Additionally Resident #113 MDS revealed the resident required substantial/maximal assistance for tasks including self-care and mobility as per Section GG-Functional Abilities. Record Review of Resident #113's care plan dated 09/21/2024 revealed that the resident was prescribed Aspirin Clopidogrel 325mg with delayed release as an antiplatelet dated 1/1/2019 under orders, which could increase the risk of bleeding. As per Resident #113's care plan, resident required one staff member assistance for bed mobility, bathing, personal hygiene, and toileting. An observation on 09/14/2025 at 11:07 AM revealed Resident #110 and #113's shared room was vacant and neat; surveyor observed an uncapped disposable shaving razor left unattended on the counter inside the shared bathroom. In an interview on 09/16/2025 at 11:39 AM, CNA D reported CNAs and nurses were responsible for providing shaving supplies and shaving services for residents. CNA D stated the supplies were in the supply storage room by the DON's office at the intersection of the 300 and 500 halls. CNA D reported that the razors the facility provides are single use and must be discarded in the sharp's container after single use. CNA D stated that nursing and CNAs were responsible for recovering and discarding the shaving razor. CNA D reported a razor left behind in a resident's room poses additional danger and infection control. CNA D reviewed Fundamentals of Infection Control Precautions Policy section 6 Resident Care Equipment and Articles and stated shaving razors were considered invasive resident care equipment. CNA D could not recall the last in-service or training received for sharps disposal. In an interview on 09/16/2025 at 11:52 AM, LVN C reported residents were provided shaving when they were bathed or upon request. LVN C stated residents were allowed to shave themselves, but it must be in their care plan. LVN C reported CNAs and LVNs were responsible for completing shaving services, supplies, and properly discarding afterward. LVN C stated razors must be capped and discarded in the sharps container located on the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER St. Teresa Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10350 Montana Avenue El Paso, TX 79925	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication carts. LVN C reported residents could harm themselves, cause bodily injuries, and could become an infection control issue. LVN C stated she did not recall the last training she received for sharps. LVN C reviewed Fundamentals of Infection Control Precautions Policy section 6 Resident Care Equipment and Articles and stated shaving razors were considered invasive resident care equipment. In an interview on 09/16/2025 at 12:54 PM, RN E reported residents were usually shaved in the shower, upon request, or care planned for residents wishing to shave independently. RN E stated staff must discard the razor in the sharps container after providing services. As per RN E, sharps containers were in the community shower rooms and on the med carts. RN E stated, CNAs and nurses were responsible for administering shaves, and reported housekeeping could toss the razor when capped or notify nursing staff. RN E reported by not properly discarding the razors, residents were exposed to potential for injury, infection control, and additional hazards in their environment. RN E reviewed Fundamentals of Infection Control Precautions Policy section 6 Resident Care Equipment and Articles and stated shaving razors were considered invasive resident care equipment. In an interview on 09/17/2025 at 10:58 AM, Resident #110 stated he had shaved on the morning of 09/14/2025 when the survey team had initially entered. Resident #110 reported he usually wakes up at 05:00 AM every day and completed his ADLs, including shaving, independently by 06:00 AM to 06:30 AM. Resident #110 reported that staff had provided him the shaving razor in the early morning of 09/14/2025 and he had completed shaving and showering at approximately 06:30 AM; Razor was in resident's room at 11:08 AM. In an interview on 09/16/2025 at 01:12 PM, DON stated shaving razors were in the supply room near the nurse's station between 300 and 500 halls. DON reported that depending on the care plan residents, staff, or family are permitted to provide shaving service. DON stated after the shaving services are completed the razor must be properly disposed in the sharps container that is in the community shower and on the medication carts. DON reported the staff who provided the razor is responsible for recovering the razor and properly disposing it as residents are not responsible for discarding the used razor. DON was provided a picture of surveyor observation; DON stated the image of the uncapped razor left in the resident's restroom was inappropriate. DON reported there was potential for harm in the form of bodily injury and transmitting blood borne pathogens (infection control) for other residents and staff members. DON was unable to recite when the last in-service and training was conducted for properly disposing in sharps container. In an interview on 09/17/2025 at 01:33 PM, the Administrator reported residents can provide shaving to themselves if it was care planned, or staff can provide shaving/ADL care upon request. The Administrator reported that staff members (CNA's, Nurses) need to supply the razor to the resident; Residents do not have access to the supply room to obtain a razor themselves. The Administrator stated the razors must be properly disposed in the sharp container after use. As per the Administrator, the sharps containers can be located in the community showers and medication carts. The Administrator stated employees (CNAs, nurses, housekeeping) were responsible for recovering the used razor and properly disposing it into the sharps containers. The Administrator reported that sharps left unattended pose a risk to the residents due to exposure to Blood borne pathogens. The Administrator was provided a photo of surveyor observation and attested the razor being left there was not appropriate. The Administrator reviewed Fundamentals of Infection Control Precautions Policy section 6 Resident Care Equipment and Articles and denied knowing if the razor was considered invasive or non-invasive as per policy and would seek clarification from DON. The Administrator returned at approximately 02:00 PM with, Nursing Policy & Procedure Manual titled Shaving, Electric/Safety Razors. As per record review, the facility provided a policy titled Shaving, Electric/Safety Razors under the Nursing Policy & Procedure Manual and Fundamentals of Infection Control Precautions Policy under the Infection Control Policy & Procedure Manual under Fundamentals of Infection Control Precautions Policy section 6 Resident Care Equipment and Articles stated, Used sharps are never recapped and always placed in puncture-resistance containers. Invasive resident care equipment (i.e., scalpel, sharps) will be single use only. As per Shaving, Electric/Safety Razors (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, Usually, the resident or a staff member performs the procedure, but the nurse can shave the resident if illness or disability prevents independence . (under goals) resident will be free from infection. The resident will maintain intact skin integrity . (procedure) store all articles in appropriate place. When finished, dispose of the gloves and wash your hands.		

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NAME OF PROVIDER OR SUPPLIER St. Teresa Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident and failed to ensure drug records were in order and that an account of all controlled drugs was maintained for 1 (Resident#33) of 6 reviewed for medication administration. The facility failed to ensure Licensed Staff Registered Nurse E signed the individual control drug record for Resident #33's after administering controlled medication on 09/16/2025. This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances. The findings include:Record review of Resident #33's admission record 09/17/2025 revealed a [AGE] year-old female with an original admission date of 07/25/2025 and a readmission date of 08/13/2025. Review of Resident #33's history and physical dated 08/13/2025 revealed diagnoses of skin transplant (surgical procedure where healthy skin is transplanted to cover damaged or missing skin) status, tracheostomy status (surgical process that creates an opening in the windpipe through the front of the neck providing an artificial airway for breathing) and gastrostomy status (presence of a surgically placed tube that provides direct access to the stomach). Review of Resident #33 's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Review of Resident #33's Care Plan revised 08/04/2025 revealed resident had potential for uncontrolled pain. Review of Resident #33's Medication Administration Record (MAR) dated September 2025 revealed Lyrica Capsule 50 MG Give 1 capsule enterally every 4 hours as needed for pain. Review of Resident #33's individual control drug record for medication Lyrica on 09/16/25 at 12:32 pm reflected 52 tablets of Lyrica and the blister packet reflected 51 tablets. In an interview on 09/17/2025 with RN E at 10:13am, revealed, that she had administered one capsule of medication to Resident #33 during the morning medication pass and had not updated the individual control drug record. She stated that she had been trained to fill it out immediately after administering medication to residents. She stated that the risk of not signing drug records in a timely manner can lead to a wrong medication count and reconciliation. In an interview on 09/17/2025 with DON at 11:00am revealed, that the purpose of the individual narcotic count record was to help keep track of controlled medications and who administered these medications. He stated that nurses were trained to sign the narcotic sheet as soon as medication was put into the cup to be administered. He stated that the risks of not filling out the narcotic record in a timely manner could result in incorrect doses being given and drug diversion. He stated that charge nurses, DON and ADONs were responsible for ensuring that these documents were being filled out appropriately. In an interview on 09/17/2025 with the Administrator at 1:30pm revealed that individual narcotic records were to ensure accountability of the medication that was being provided to the residents. He stated that narcotic sheet records that were not filled out properly posed a potential risk for medication miscount. He stated that charge nurse, DON and ADONs were responsible for ensuring these documents were properly filled out. Review of the facility's policy titled Controlled Medication Storage dated 01/2025 read in part . A controlled medication accountability record is prepared when receiving inventory of any controlled substance to establish a record of receipt and disposition in sufficient detail to enable accurate reconciliation. The following information is completed: name of resident, prescription number, name, strength and dosage form of medication, date received, quantity received and the name of person receiving medication		