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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER: Vibralife of El Paso Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3421 Joe Battle Boulevard El Paso, TX 79936	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observations, interviews, and record review, the facility failed to conduct assessments that accurately reflected the resident's status for 4 of 12 residents (Residents #10, #15, #28, and #237) reviewed for resident assessments. The facility failed to ensure Resident #10's Admission MDS Assessment accurately reflected her diagnosis of anxiety. The facility failed to ensure that Resident #15's Admission MDS Assessment accurately reflected his skin status or diagnosis of anxiety/use of anti anxiety medication. The facility failed to ensure Resident #28's Medicare 5 Day MDS Assessment accurately reflected his diagnosis of Diabetes Mellitus. The facility failed to ensure Resident #237's Admission MDS Assessment accurately reflected his diagnosis of chronic pain. These failures could place residents at risk of not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well being. The findings included: Resident #10 Review of Resident #10's Admission Record, dated 6/6/24, revealed she was an [AGE] year old female admitted to the facility on [DATE]. Review of Resident #10's Admission MDS Assessment, dated 4/18/24, revealed a BIMS score of 13 (indicating she was cognitively intact) with no signs or symptoms of delirium. She had no reported behaviors. Anxiety was not identified on her active diagnosis list. She received antipsychotic, antianxiety, antidepressant, anticoagulant, and hypoglycemic (including insulin) medications. Review of Resident #10's care plan, most recent revision date 4/30/24 revealed: Focus: I am currently on antianxiety medication related to anxiety and prone to side effects. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: The resident will be free from discomfort or adverse reactions related to antianxiety therapy through the review date. Interventions: Administer antianxiety medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Monitor/document/report as needed adverse reactions to antianxiety therapy, change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in ADL ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo; fatigue, insomnia, appetite loss, weight loss, nausea, vomiting, dry mouth, and dry eyes. Review of Resident #10's Order Summary Report, dated 6/6/24, revealed the following orders: Buspirone Hcl oral tablet 10mg give 1 tablet by mouth every 8 hours for anxiety Seroquel Oral Tablet 50mg give 1 tablet by mouth one time a day for dementia/anxiety Resident #15 Review of Resident #15's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male admitted to the facility on [DATE] with a diagnosis including difficulty walking. Review of Resident #15's May 2024 Medication Administration Record revealed he was prescribed Hydroxyzine 25mg for anxiety beginning 5/15/25 (admission). Review of Resident #15's initial MDS assessment, dated 5/22/24, revealed: He scored a 15 out of 15 on his mental status exam (indicating he was cognitively intact). Anxiety was not identified on the active diagnosis list. No wounds were identified on the initial assessment. Review of Resident #15's care plan, initiated 5/30/24, revealed: Focus Resident was on an antibiotic for Right lower extremity cellulitis. Goal: Resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions included administer antibiotic medications as ordered by the physician, monitor/document side effects, and effectiveness every shift. Review of Resident #15's Skilled nursing Flow Sheet for 5/15/25 (admission nursing note) revealed that his right and left leg had an unidentified concern, and the right foot had an unspecified issue. (No further information available in the notes, but he had some sort of wound on his right foot.) Observation and interview on 6/4/24 at 09:15 AM revealed Resident #15 sitting up in his wheelchair. Resident #15 pulled up the right pants leg and said he had a sore on the bottom of his foot. Resident #15's ankle was observed to be red and pitted. Resident #15's feet were so swollen the socks on his feet were cut at the ankle to accommodate the swelling. There was no sign or PPE to indicate Resident #15 should be on enhanced barrier precautions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 Review of Resident #28's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male originally admitted to the facility on [DATE], with a most recent admitted [DATE]. Review of Resident #28's Medicare 5 Day MDS Assessment, dated 5/25/24, revealed a BIMS score of 15 (indicating he was cognitively intact) with no signs or symptoms of delirium. He had no reported behaviors. Diabetes was not identified on his active diagnosis list. He received insulin, an antidepressant, and an antibiotic. Review of Resident #28's care plan revealed no care plan in place regarding his diagnosis of diabetes. Review of Resident #28's Order Summary Report, dated 6/5/24, revealed the following order: Insulin Lispro Injection Solution 100 UNIT/ML: Inject as per sliding scale: if 70 139 = 0 units; 140 180 = 3 units; 181 240 = 4 units; 241 300 = 6 units; 301 350 = 8 units; 351 400 = 10 units; 401+ = 12 units call MD, subcutaneously before meals and at bedtime for diabetes mellitus. Resident #237 Review of Resident #237's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male admitted to the facility on [DATE]. Review of Resident #237's Admission MDS Assessment, dated 5/23/24, revealed a BIMS score of 15 (indicating he was cognitively intact) with no signs or symptoms of delirium. He had no reported behaviors. Chronic pain was not identified on his active diagnosis list. He received scheduled pain medication and as needed pain medication. He received insulin, antibiotic, diuretic, and opioid medications (medications used to use acute and/or chronic pain) . Review of Resident #237's care plan, most recent revision date of 6/5/24, revealed: Focus: I am prone to acute and chronic pain related to chronic debility decline. Goal: The resident will not have an interruption in normal activities due to pain through the review date. Interventions: Administer analgesia as per MD orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/6/24 at 10:57 AM the MDS Coordinator stated she was responsible for completing all comprehensive assessments for residents in the facility. She stated that long term residents had a quarterly assessment completed every three months and an annual comprehensive assessment after three quarterly assessments were completed. She stated that when she did her comprehensive assessments, she definitely went to look at, and speak to the resident. She stated that when a resident had been at the facility for an extended period, diagnoses like diabetes or psychiatric illness should have been carried over from one MDS assessment to the next (annual to quarterly). She stated that she gathered information for the assessments from admission forms and from the facility's electronic health records for each resident, in addition to interviews with the resident and their family or representatives. The MDS Coordinator did not realize Resident #14's Hydroxyzine counted as an antianxiety medication since its drug classification was antihistamine. In a follow up interview on 6/6/24 at 3:29 PM, the MDS Coordinator stated that she got the diagnoses for the MDS assessments from the physician's orders or hospital history and physical documents (if the resident was admitted directly from the hospital, which was most often the case). She stated that she was the only person in the facility that completed the MDS assessments. She stated that if a resident was admitted to the facility with an order for insulin, she would make sure that there was a diagnosis on the MDS assessment for diabetes or if there were multiple orders with a diagnosis of chronic pain, that there was a corresponding diagnosis on the MDS assessment. She stated that, in the case of Residents #28 and #237, she did not know why their diagnoses of diabetes and chronic pain were missed, especially since the medications themselves were addressed in both resident's assessments. She stated she believed that Resident #10's diagnosis of anxiety was added after her assessment had been completed and that was the reason it was not included on the MDS assessment. In an interview on 6/6/24 at 4:17 PM with the DON, she stated that the facility referred to the MDS 3.0 RAI Manual provided by CMS for facility procedure regarding resident assessment .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26221 Resident #15 Care Planning Copied from another care area: [NAME], [NAME] (26221) 06/04/24 02:23 PM No communicateion w VA as res believes documented 34486 Based on interviews and record review the facility failed to develop and implement a comprehensive, person centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well being for 3 of 6 residents (Residents #10, #15, and #28) reviewed for care plans. Resident #10 did not have a care plan to address her antipsychotic use. Resident #15 did not have a care plan to address CAA areas of vision, psychosocial status, urinary status, skin status, active diagnosis, or anti anxiety use. Resident #28 did not have a care plan to address his diabetic status or insulin use. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included the following: Resident #10 Review of Resident #10's Admission Record, dated 6/6/24, revealed she was an [AGE] year old female admitted to the facility on [DATE]. Review of Resident #10's Admission MDS Assessment, dated 4/18/24, revealed a BIMS score of 13 (indicating she was cognitively intact) with no signs or symptoms of delirium. She had no reported behaviors. She had diagnoses of non Alzheimer's dementia, cognitive communication deficit, and Type 2 Diabetes Mellitus. She received antipsychotic, antianxiety, antidepressant, anticoagulant, and hypoglycemic (including insulin) medications. Review of Resident #10's care plan, most recent revision date 4/30/24 revealed no care plan in place regarding her use of an antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's Order Summary Report, dated 6/6/24, revealed the following order dated 05/17/24: Seroquel Oral Tablet 50mg give 1 tablet by mouth one time a day for dementia/anxiety Resident #15 Review of Resident #15's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male admitted to the facility on [DATE] with a diagnosis including difficulty walking. Review of Resident #15's initial MDS assessment, dated 5/22/24, revealed: He had impaired vision and wore corrective lenses. He scored a 15 out of 15 on his mental status exam (indicating he was cognitively intact). He was occasionally incontinent of bladder. Active diagnoses included anemia and hypertension. (Anxiety was not identified.) He was at risk for developing pressure ulcers but no wounds, including foot problems, were identified on the initial assessment. His antianxiety use was not identified. Review of Resident #15's May 2024 Medication Administration Record revealed he was prescribed medications: Hydroxyzine 25mg for anxiety beginning 5/15/24. Lisinopril 2.5mg for hypertension beginning 5/16/24. Metoprolol Tartrate 25mg for hypertension beginning 5/16/24. Review of Resident #15's Skilled nursing Flow Sheet for 5/15/25 (admission nursing note) revealed that his right and left leg had an unidentified concern, and the right foot had an unspecified issue. (The note indicated there was some form of wound on the right foot but no further information was found.) Review of Resident #15's care plan, initiated 5/30/24, revealed: Focus Resident was on an antibiotic for right lower extremity cellulitis. Goal: Resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions included administer antibiotic medications as ordered by physician, monitor/ document side effects, and effectiveness every shift. (There was no care plan to address the type or frequency of the wound care, there was no care plan to address any enhanced barrier precautions.) There was no care plan to address Resident #15's vision status, communication, urinary status, psychosocial function, or skin status triggered in the CAA section of the MDS. Observation and interview on 6/4/24 at 09:15 AM revealed Resident #15 sitting up in his wheelchair. Resident #15 pulled up the right pants leg and said he had a sore on the bottom of his foot. Resident #15's ankle was observed to be red and pitted. Resident #15's feet were so swollen the socks on his feet were cut at the ankle to accommodate the swelling. There was no sign or PPE to indicate Resident #15 should be on enhanced barrier precautions. Resident #28 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #28's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male originally admitted to the facility on [DATE], with a most recent admitted [DATE]. Review of Resident #28's Medicare 5 Day MDS Assessment, dated 5/25/24, revealed a BIMS score of 15 (indicating he was cognitively intact) with no signs or symptoms of delirium. He had no reported behaviors. He had diagnoses of obstructive uropathy, septicemia, hyperlipidemia, paraplegia, seizure disorder, depression, osteomyelitis, insomnia, history of stroke, and cognitive communication deficit. He received insulin, an antidepressant, and an antibiotic. Review of Resident #28's care plan revealed no care plan in place regarding his diagnosis of diabetes. Review of Resident #28's Order Summary Report, dated 6/5/24, revealed the following order dated 05/18/2024: Insulin Lispro Injection Solution 100 UNIT/ML: Inject as per sliding scale: if 70 139 = 0 units; 140 180 = 3 units; 181 240 = 4 units; 241 300 = 6 units; 301 350 = 8 units; 351 400 = 10 units; 401+ = 12 units call MD, subcutaneously before meals and at bedtime for diabetes mellitus . Interview on 06/06/24 at 10:57 AM the MDS Coordinator stated she was responsible for the comprehensive care plan. She stated she care planned medications, risk for falls, pain, pressure ulcers, anticoagulant use, antidepressant use, all of that . She stated she did the care plan if the resident was at the facility for more than 21 days. She said after 21 days, the comprehensive care plan replaced the baseline care plan completed by the nurses on admission. The MDS Coordinator stated, everyone uses the care plan. The MDS Coordinator said she did not know why there would be sections where there were no interventions that came through on the care plan. The MDS Coordinator stated she did not think there was a care plan for Resident #15's vision, communication, urinary, psychosocial function, or skin status. She was informed those were all CAA areas. The MDS Coordinator stated she would expect to see a care plan for an anti anxiety medication. The MDS Coordinator said that Hydroxyzine was an antihistamine. She was informed it was prescribed for the use as an anti anxiety and replied, yes she would expect to see a care plan for anxiety. The MDS Coordinator agreed the care plans were not accurate at all because the nurse's base line care plans needed to be more accurate. The MDS Coordinator stated if an LVN did an admission they could not do the staging of a wound so all they could do was document that a wound did exist. That resulted in an inaccurate MDS and an inaccurate comprehensive care plan because the staging did not get communicated. The MDS Coordinator said she monitored care plans by attending clinical meetings. The MDS Coordinator said if she became aware something was needed, she went into the care plan, and entered it. The MDS Coordinator stated the potential risk to the resident for the care plan not being done was the care not getting done. During a follow up interview on 06/06/24 at 11:47 AM the MDS Coordinator stated she had training on how to do care plans, but it had not been recent. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/6/24 at 3:29 PM, the MDS Coordinator stated she started the comprehensive care plan based on the MDS assessment. She said that when she started the comprehensive care plan for a resident, she included the care areas she saw in the assessment she had completed. She stated that Resident #28's care plan was missing diabetes and insulin because he was a resident prior to his current admission and his old care plan was not reactivated. She stated that any nurse was able to do this when a resident was readmitted to the facility during the admission process, but the floor nurses that completed the admissions did not do it often. She stated that Resident #10's care plan for antipsychotic medication use should have been completed by the nurse who did her admission to the facility. She stated that all facility nurses were able to add to or create new items in each resident's care plan. She stated that she did not routinely go back and look at the care plans once she had done her part on them unless she was personally made aware of a change that was needed . Review of the facility's policy and procedure on Comprehensive Care Plans, dated 8/18/17 revealed, Policy: It is the policy of [Corporation] to develop and implement a comprehensive person center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the resident's compressive assessment. Policy Explanation and Compliance Guidelines: Person centered means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. The comprehensive care plan will describe, at a minimum, the following: a. the services that are to be furnished to attain or maintain the resident's highest practicable mental and psychosocial well being. b. any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. d. the resident's goal for admission, desired outcomes, and preferences for future discharge, e. discharge plans as appropriate. 45411 Resident #10 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/06/24 02:39 PM Resident is receiving Seroquel for dx of dementia and anxiety. The anxiety diagnosis is not identified on the MDS. The MDS states that the resident is taking an antipsychotic medication without an indication. There is no care plan in place for the use of an antipsychotic medication. Resident #28 FTag Initiation 06/05/24 10:00 AM MDS did no reflect resident's diagnosis of diabetes mellitus. Care plan did not address resident's diagnosis of diabetes or use of insulin.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observations, interviews, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 1 of 2 residents (Resident #237) reviewed for peripheral intravenous care. The facility failed to ensure Resident #237's midline dressing was changed after becoming soiled on 6/2/24. This failure could place residents at risk of developing an infection. The findings included: Review of Resident #237's Admission Record, dated 6/5/24, revealed he was a [AGE] year old male admitted to the facility on [DATE]. Review of Resident #237's Admission MDS Assessment, dated 5/23/24, revealed a BIMS score of 15 (indicating he was cognitively intact) with no signs or symptoms of delirium. He had diagnoses of multi drug resistant organism and septicemia. He received insulin, antibiotic, diuretic, and opioid medications. He received IV medications and had IV access. Review of Resident #237's Progress Notes revealed the following: Nurse's Note dated 6/2/24 at 10:03 AM Resident completed vancomycin IV therapy in AM, noted dressing wet. Upon administration of flushing with 0.9% NS, noted leaking in dressing. MD and NP notified, received new order for new midline to be placed by 'outside company'. Call placed at this time, as per representative, RN will be in facility today to have it placed. Review of Resident #237's care plan, most recent revision date of 6/5/24, revealed: Focus: I am on IV Vancomycin via midline for pneumonia and prone to complications. Goal: Midline will show no signs/symptoms of infection and other complications through the next review date. Interventions: Administer IV fluids/antibiotic as ordered. Change dressing every 7 days and PRN per facility policy. Flush midline as ordered. Monitor every shift for signs/symptoms of infection. Notify MD of any changes. Review of Resident #237's Order Summary Report, dated 6/5/24, revealed the following orders: IV Site Change dressing once weekly and PRN. Measure extending line and check for displacement. If more than 1 cm, notify physician for further orders (day shift every 7 days AND as needed). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/4/24 at 09:32 AM, Resident #237 was observed sitting in a chair in his room. Resident #237 had a single lumen midline noted to his left upper arm. The dressing, dated 5/28/24, was brown tinged and peeling away from the resident's skin. Resident #237 stated that the dressing got wet a few days ago when a student nurse was flushing the line and the syringe wasn't connected all the way. He stated that the staff nurse checked it and had someone from the hospital come to check it because they thought the line itself was leaking, but everyone said it (the midline) was fine and to leave the dressing in place. Resident #237 was unable to remember the date of the occurrence. In an interview on 6/6/24 at 10:20 AM with ADON A and ADON B, ADON A stated the facility worked with a company that placed midlines and came to the facility to check placement/replaced them when they were not working. ADON A stated that the company did send a nurse to assess Resident #237's midline on 6/3/24 but the line itself was functioning and the placement was good, so they did nothing to it. ADON B stated that facility nurses were responsible for midline dressing changes per MD orders, which were typically to change the dressing every 7 days and PRN. ADON A and ADON B both stated that the dressing should have been changed but ADON A stated it wasn't that bad and she had seen worse . In an interview on 6/6/24 at 4:17 PM with the DON, she stated that when they completed their midline site assessments, nurses should ensure midline dressings were clean, dry, and intact, with no debris getting into the midline. She stated that all facility nurses could do midline dressing changes as long as they had been trained. She stated all staff nurses were offered the training. She stated it was not a required training, but nursing management strongly encouraged that all nurses received the training. She stated that nurses were to assess midline sites at least once a shift, so the sites were looked at no less than every 12 hours. She stated that Resident #237's midline dressing should have been changed per facility policy because it was soiled and was peeling away from his skin. She stated that the most critical possible negative outcome of a soiled dressing remaining on the resident was an increased risk of infection. Review of facility policy titled Midline Dressing Changes, effective date 4/1/11, revealed, in part: Policy: Midline catheter dressing will be changed at specified intervals, or when needed, to prevent catheter related infections associated with contaminated, loosened or soiled catheter site dressings. General Guidelines: Change midline catheter dressing every 7 days, or if it is wet, dirty, not intact, or compromised in any way.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibralife of El Paso Rehabilitation Center	3421 Joe Battle Boulevard El Paso, TX 79936

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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** 33198 34486 Based on interviews and record review the facility failed to ensure that residents who have not used psychotropic drugs [NAME] not given these drugs unless the medication [NAME] necessary to treat a specific condition as diagnosed and documented in the clinical record for 3 (Residents #10, #21, and #137) of 5 residents reviewed for unnecessary medications., The facility failed to ensure Resident #10 had an appropriate diagnosis for the use of Seroquel (an antipsychotic used to treat schizophrenia and bipolar disorder). The facility failed to ensure Resident #21 was not given risperidone (an antipsychotic) without a diagnosis. The facility failed to ensure that Resident #137 did not receive an antipsychotic (Seroquel/Quetiapine Fumarate) that was not necessary to treat Dementia. These failures put residents at increased risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status from receiving unnecessary antipsychotic medications. Findings included: Resident #10 Review of Resident #10's Admission Record, dated 6/6/24, revealed she was an [AGE] year old female admitted to the facility on [DATE]. Review of Resident #10's Admission MDS Assessment, dated 4/18/24, revealed a BIMS score of 13 (indicating she was cognitively intact) with no signs or symptoms of delirium. She had no reported behaviors. She had diagnoses of non Alzheimer's dementia, cognitive communication deficit, and Type 2 Diabetes Mellitus. She received antipsychotic, antianxiety, antidepressant, anticoagulant, and hypoglycemic (including insulin) medications. Review of Resident #10's care plan, most recent revision date 4/30/24 revealed no care plan in place regarding her use of an antipsychotic medication. Review of Resident #10's Order Summary Report, dated 6/6/24, revealed the following order: Seroquel Oral Tablet 50mg give 1 tablet by mouth one time a day for dementia/anxiety Resident #21 (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 #21's face sheet dated 6/5/2024 revealed she was [AGE] years old, initially admitted on [DATE], and readmitted [DATE]. Record review of Resident #21's Assisted Living Facility admission documents dated (04/08/2022) indicated a history of delusions and was taking risperidone (anti psychotic) 0.5 MG twice a day. Record review of Resident #21's Geriatric Behavioral Care Unit history and physical dated 11/25/2023 revealed she had visual and tactile hallucinations. She was taking risperidone 0.25 mg tablets (antipsychotic) at bedtime. Record review of Resident #21's annual MDS assessment dated [DATE] revealed she had a BMS score of 5 (severe cognitive impairment). She had diagnoses including dementia and depression. Record review of Resident #21's electronic diagnosis listing dated 06/05/2024 revealed she had a diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident # 21's Care plan dated 12/07/2023 revealed she took risperidone for major depression with psychosis. Record review of Resident #21's physician's order dated 06/03/2024 for Risperdal (brand name risperidone) 0.5 MG to be given at bedtime revealed the order did not indicate what the medication was to treat. Record review of Resident #21's June 2024 MAR revealed she received 0.5 MG of Risperdal on June 3, 4, and 5 without an indication of what the medication was intended to treat. In an interview on 06/06/24 at 10:27 AM the DON revealed when a medication [NAME] prescribed the prescription needed to indicate what the medication was intended to treat. This ensured that the resident received the correct medication for the correct diagnosis. She stated the nurse should clarify with doctor that the appropriate medication was being given for the resident's diagnosis, and this should have been done for Resident #21. She stated that Risperdal could put residents at risk for adverse side effects, somnolence (sleepiness), disorientation, and falls. Resident #137 The findings included: Record review of Resident #137's face sheet indicated he was an [AGE] year old male admitted to the facility on [DATE] and re admitted on [DATE] with the diagnoses of unspecified dementia (brain impairment), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and lack of coordination. Record review of Resident #137's admission MDS assessment dated [DATE] indicated he had a BIMS score of 11 which indicated she had moderate cognitive impairment. The MDS also did not indicate the resident had a diagnosis to support the use of anti psychotic medication Seroquel/Quetiapine, but Resident #137 received the medication on a routine basis. (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 #137's care plan for May 2024 indicated no specific plan for Seroquel use as psychotropic medications. Record review of Resident #137's order summary report dated 04/13/24 indicated he had an order for Quetiapine Fumarate Tablet 25mg (an antipsychotic medication used to treat schizophrenia and bipolar disorder). Give 1 tablet via G tube at bedtime for sundown syndrome/agitation. During an interview on 06/05/24 at 3:51 p.m., the DON said she was not aware Resident #137 was receiving antipsychotic medication, of Seroquel. She explained she was made aware by a staff member during the resident's discharge. She stated there was no documentation by the physician regarding the reason the resident was receiving this medication without the right diagnosis. The DON explained she has been in the facility since last month and trying to review the medications to ensure the residents were getting meds according to their diagnosis . Record review of the facility's policy for use of antipsychotic drugs undated reflected: Policy: It is the facility's policy that each resident's drug regimen is free from unnecessary drugs, including unnecessary antipsychotic drugs. Policy Explanation and Compliance Guidelines: Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drugs therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Generally, these conditions include: a. Schizophrenia, schizo affective disorder, schizophreniform disorder b. Delusional disorder c. Mood disorders (e.g., bipolar disorder, severe depression refractory to other therapies and/or with psychotic features) d. Psychosis in the absence of dementia e. medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related to psychosis or mania (e.g., high dose steroids) f. Tourette's Disorder g. Huntington disease (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Hiccups (not induced by other medications) i. Nausea and vomiting associated with cancer or chemotherapy. 45411

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26221 Based on observations, interviews, and record review the facility failed to store all drugs and biologicals in locked compartments for 3 of 4 medication carts reviewed for medication storage and security. Medication Carts 100, 200, and 300 were left in the hallway unlocked and unattended. These failures could place clients at risk for drug diversion or accidental ingestion. Findings included: Observation on 06/04/24 at 08:57 AM revealed the hall 100 medication cart was unlocked and unattended in front of a resident's room. Staff moved it to in front of the nurse's station facing outward still unlocked and unattended, facing outward (anyone passing by have access to the drawers), and walked away from it. At 9:02 a.m. staff returned to the cart, set up medication and then left, again leaving the cart unlocked and unattended. The staff continued to leave the cart unlocked and unattended until surveyor left at 9:11 a.m. Observation on 06/04/24 at 08:38 AM LVN C walked away from the 300 Hall Medication Cart leaving it unlocked, unattended, and facing outward. At 8:42 AM the Medication Cart was observed to be still unlocked and unattended with staff walking right by it. Observation on 06/04/24 at 11:48 PM revealed the 200 Hall medication cart was unlocked, unattended, and facing out at the nurse's station. Observation on 06/04/24 at 12:37 PM revealed the 200 Hall and 300 Hall medication carts were unlocked, unattended, and facing outward at the nurse's station. Observation on 06/04/24 at 02:29 PM revealed the 200 Hall medication cart was unlocked, unattended, and facing outward at the nurse's station. Interview on 06/05/24 at 01:52 PM with both ADONs and the DON revealed the expectation for the medication carts were that they were locked when the nurse stepped away from it. The ADONs said they monitored that medication carts were locked by doing frequent rounding and they checked that keys were not left on top of the cart and that the lock was pushed in. The DON said the potential to the residents for unlocked unattended medication carts were the potential for drug diversions or residents getting into the medication cart. Interview on 06/06/24 at 11:49 AM the Administrator stated the DON informed her of the medication carts being left unlocked and unattended. The Administrator said, that was nursing 101 but it happened because of changes in staff and was super fixable . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure on Storage and Expiration of Medications, Biologicals, Syringes and Needles, effective 12/1/07 revealed: Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medication in compliance with Applicable Law. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 34486

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observations, interviews, and record review, the facility failed to provide laboratory services to meet the needs of its residents, for 1 of 3 (Resident # 136) residents reviewed for laboratory orders. The facility failed to follow physician orders on 05/29/24 that required obtaining a lab and provide needed treatment for Resident #136. This failure could place residents at risk for untreated medical issues and diminished quality of care. Findings included: Record review of Resident # 136's face sheet dated 06/06/2024 reflected a [AGE] year old female admitted on [DATE] with a diagnoses of acute embolism (blocked artery), thrombosis (blood clot), difficulty in walking, and weakness. Record review of Resident #136's admission MDS assessment dated [DATE] reflected Resident #136 had a BIMS score of 15, which indicated intact cognition. Resident #137 did not have any behavioral or mood issues. She was continent of bowel and bladder. Resident #137 ambulated by self and required limited assistance with most ADLs . Record review of Resident #136's Physician Orders dated 05/29/24 reflected the following laboratory to be performed by the facility: 1) ESR Erythrocyte Sedimentation rate 2) CBC with differential (Complete blood count) 3) C Reactive protein test to check for inflammation, infection, and heart disease risk. During an interview with Resident #136 on 06/04/24 at 8:36a.m, she said she has been in the facility for a few weeks. She explained she was doing well except that the facility has not been able to provide a laboratory test ordered by her doctor after an appointment visit. She stated she had talked to the nurses, and none seemed to know what happened to her physician orders. Resident #134 explained her RP took her to the doctor's appointment and gave the order to one of the nurses. In an interview with her RP on 06/04/24 at 12:43p.m, he said he was the responsible party for Resident #136. He explained he took the resident to her orthopedic doctor's appointment and received orders from the physician for some needed lab work to be done. He gave the order to the charge nurse, LVN B, so the test could be done. The RP said he has been calling and no one seems to know where the physician orders were kept. He stated it was important that the test was done so Resident #136 can receive timely and needed treatment. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 06/05/24 at 3:40p.m, she stated she was aware Resident #136 had an appointment with her doctor but did not bring back a physician order. She stated she informed her that Resident #136's RP confirmed he gave the physician orders to the charge nurse on duty . During an interview with LVN B on 06/06/24 at 11:42a.m, she was the charge nurse on duty when the RP came to the facility. She explained she remembered talking to the RP about Resident #136's Laboratory test. She did not remember receiving the physician orders. LVN B explained it was a crazy day having to complete 2 new admissions that day. She said she cannot say with certainty she received physician orders from the RP. She stated she cannot say if she did or didn't receive the physician orders . Record review of the policy on physician orders undated reflected the following: Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. Policy Explanation and Compliance Guidelines: 1. Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the resident's attending physician or physician/practitioner who is acting on behalf of the attending physician. A consulting physician/practitioner may include, but is not limited to, a resident's: a. Surgeon b. Dialysis physician/nephrologist c. Wound clinic physician. d. Specialist such as urologist, cardiologist, gastroenterologist, dentist, ophthalmologist, OB/GYN e. Nurse practitioner, clinical nurse specialist, or physician assistant to any of the above physicians.

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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. 45411 Based on observations and interviews 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 reviewed for kitchen sanitation. The facility failed to ensure stored foods were properly stored, labeled, and dated. This failure could place residents who received prepared meals from the kitchen at risk for food borne illness and cross-contamination. The findings included: Observation on 6/4/24 at 8:45 AM of the walk-in refrigerator revealed a large plastic tub on the bottom rack of shelving that contained a large, torn open, plastic bag of raw, pre-cut white meat. The bag containing the meat had no label or date. The plastic tub had approximately 0.5 inch of bloody liquid collected in the bottom where it had leaked out of the open bag of meat (no spillage was noted outside of the tub). Observation on 6/4/24 at 8:50 AM of the walk-in freezer revealed one 5-pound bag of frozen, sliced, yellow-colored vegetables with no label and no date. In an interview on 6/5/24 at 12:20 PM, the Food Service Director stated that the meat in the plastic tub had been placed there to thaw but he was not certain of the date it was removed from the freezer. He stated that he was not aware that the bag the meat was in was open. He stated the bag should have been sealed and labeled with what the meat was and a use by date or the date it was placed in the refrigerator to thaw. The FSD stated that the bag of vegetables in the freezer should have been labeled with what the contents were when the bag was removed from the original box it came in even though it was obvious that it was a bag of French fries . In an interview on 6/5/24 at 12:20 PM, the Registered Dietician stated that all food, when removed from the original packaging, should be labeled, and dated with a use by date or a received on. He stated that the meat in the plastic tub should have been placed in smaller, resealable bags to thaw in the refrigerator to prevent leaking. The RD stated that the bag of vegetables in the freezer should have been labeled with what the bag contained and a received-on date when they were removed from their original packaging . Review of undated facility policy titled Food Receiving and Storage revealed, in part: All foods stored in the refrigerator or freezer will be covered, labeled, and dated ('use by' date).

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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 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections for 4 (Resident #137, #8, #15, #87) of 6 reviewed for incontinent care and 3 of 4 residents reviewed for infection control practices. The facility failed to ensure that CNA D performed proper hand hygiene and glove changes while providing incontinence care to Resident #137. The facility failed to ensure residents were identified for enhanced barrier control for Residents #8, #15, #87. This failure could place residents at risk for the spread of infection. Findings included: Incontinent Care Review of Resident #137's face sheet dated 06/06/24, revealed a 69- year- old male admitted to the facility on [DATE] with diagnoses including Pulmonary embolism and diabetes mellitus. Review of Resident #137's admission MDS assessment dated [DATE] revealed Resident #137 required set up with most activities of daily living (ADLs) and one-person physical assistance with transfer. Resident #137 was occasionally incontinent of bowel and bladder. Review of Resident #137's Care Plan dated 06/03/24 revealed no plan for bowel or bladder incontinence. Observation of incontinence care for Resident #137 on 06/06/24 at 10:10 a.m. revealed CNA D washed her hands before start of care. She removed the resident ' s soiled brief. Resident #137 ' s brief was soiled with urine and fecal matter. CNA D wiped the resident from front to back. CNA D's gloves were visibly soiled with fecal matter. She did not wash her hands, change gloves, or perform hand hygiene before putting on Resident #137's clean brief and placing it underneath him. She fastened the clean brief with the same soiled gloves. CNA D retrieved the trash and walked out of Resident #137 ' s room without washing her hands. In an interview on 06/06/24 at 10:18 a.m. with CNA D, she revealed she should have changed her gloves before retrieving a clean brief and placing it underneath Resident #137. CNA D stated she has been in the facility 1 month and had infection control training during orientation. She said the resident could acquire an infection when she did not follow good infection control practices including washing hands before commencing care. (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 with the DON on 06/06/24 at 1:40 p.m., she revealed she was aware of some of the concerns raised about infection control. She stated she expected the aides to follow the facility protocols during care, one of which was to ensure hand washing and change of gloves as needed while providing care. Review of the facility's perineal care policy dated 08/16/17 reflected the following: PURPOSE: It is (this company ' s policy) practice to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. POLICY: All staff members involved in performing perineal care to residents will promote cleanliness, prevent infections to the extent possible, prevent and assess for skin breakdown and promote comfort. 1. Practice Guideline observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy annually and as needed. PROCEDURE 2. Gather supplies needed . a. Basin Method: i. Basin ii. Towels iii. Perineal Cleanser iv. Drape (If applicable) b. Disposable Wipe Method i. Wipes ii. Towels iii. Drape (If applicable) 3. Always rinse after washing, unless using a non-rinse cleanser. 4. Maintain clean technique and observe isolation precautions when applicable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Knock and gain permission to enter resident ' s room. 6. Provide privacy. 7. Inform resident on procedure to be performed. 8. Set up supplies. Enhanced Barrier Protection Review of Resident #8 ' s Admission Record, dated 6/5/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including osteomyelitis (bone infection). Review of Resident #8 ' s Admission MDS Assessment, dated 5/3/24, revealed: His mental status score was 13 of 15 (indicating he was cognitively intact). He received IV medications while in the facility and was admitted with a midline (IV placed in a deep vein in the upper arm). Review of Resident #8 ' s Care Plan revealed: Care plan initiated 5/29/24 for Resident #8, he has a foley catheter for urinary retention. The identified goal was that the resident will remain free from catheter-related trauma through review date. Identified interventions included Monitor/report to doctor for signs or symptoms of urinary tract infection. Observation on 06/04/24 at 08:25 AM revealed Resident #8 in bed. Resident #8 had a catheter. Resident #8 had nothing outside his room notifying staff about enhanced barrier precautions posted or additional PPE available. Review of Resident #15 ' s Admission Record, dated 6/5/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including difficulty walking. Review of Resident #15 ' s initial MDS assessment, dated 5/22/24, revealed: He scored a 15 of 15 on his mental status exam (indicating he was cognitively intact) No wounds were identified on the initial assessment. Review of Resident #15 ' s care plan, initiated 5/30/24, revealed: Focus Resident was on an antibiotic for right lower extremity cellulitis. Goal: Resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions included administer antibiotic medications as ordered by physician, monitor/ document side effects, and effectiveness every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Vibralife of El Paso Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 6/4/24 at 09:15 AM revealed Resident #15 sitting up in his wheelchair. Resident #15 pulled up the right pants leg and said he had a sore on the bottom of his foot. Resident #15 ' s ankle was observed to be red and pitted. Resident #15 ' s feet were so swollen the socks on his feet were cut at the ankle to accommodate the swelling. There was no sign or PPE to indicate Resident #15 should be on enhanced barrier precautions. Review of Resident #87 ' s Admission Record, dated 6/5/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease. Review of Resident #87 ' s Order Summary, dated 6/5/24 revealed she received dialysis services three times a week. Observation and interview on 06/04/24 at 09:02 AM revealed Resident #87 ' s room had an oxygen sign posted, but nothing about enhanced barrier precautions. Resident #87 was not in the room and LVN C stated Resident #87 was at dialysis. Observation on 06/05/24 at 08:17 AM showed Residents #8, #15, and #87 ' s room did not have anything posted about enhanced barrier protection or any PPE outside of the resident ' s rooms. Interview on 06/05/24 at 02:09 PM with the DON, and both ADONs, the DON stated Enhanced Barrier precautions was a CDC recommendation started on 4/1/24 for anyone with an indwelling device: a g-tube (feeding tube), a catheter, or open wounds. The DON stated anything that went internally into a resident. The DON said enhanced barrier protection required a gown and gloves if the staff provided direct patient care. The DON stated the facility had seven (7) residents with open wounds, two (2) with g-tubes, three (3) with catheters, six (6) with dialysis shunts, and two (2) with intravenous medications. The DON said at the time of the survey the staff were just wearing gloves to meet the enhanced barrier protection needs of those residents. The DON stated the facility was waiting on direction from the corporation on ordering bins to have outside of the doors. The DON said the facility had some PPE holders that went over the door but they (the DON and ADONs) did not know what the corporation wanted to do. The DON said there were still PPE containers left from the covid isolation epidemic. The DON and ADONs said they had been at the facility for three weeks. The ADONs said the outcome to the residents included transferring bacteria and infection to residents due to open areas if PPE was not worn. The DON said Resident #87 was on dialysis and needed enhanced barrier protection. The DON said the facility did not implement enhanced barrier protection because not every staff member was in-serviced on PPE use yet. The DON said no resident had a facility-acquired infection because of the staff not following enhanced barrier precautions. Interview on 06/06/24 at 11:49 AM the Administrator stated the DON did let her know about the enhanced barrier precautions. The Administrator was informed that the CMS expectation had been in place since April. The Administrator said it was not implemented at this facility because the facility had just changed DONS and the facility did not see the CDC guideline. The Administrator said she was not aware she could take the infection control preventionist course as a non-clinical staff as a way to understand the regulation better. Review of the In-service dated 6/5/24 revealed: Enhanced Barrier Precautions to be implemented for all patients with indwelling devices that may cause them to be at greater risk for infection transmission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Vibralife of El Paso Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	You will soon see an increase in the circumstances with we are asking you to wear a gown and gloves while caring for residents. This is based on new recommendations from the Centers for Disease Control and Prevention to prevent our residents and staff from multidrug-resistant organisms (MDRO), which can cause serious infections and are hard to treat. These new recommendations are called Enhanced Barrier Precautions. Enhanced Barrier Precautions require staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MRDO. These include the following residents: Residents known to be infected or colonized with an MRDO. Residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube (PEG Tube, G-tube), tracheostomy/ventilator regardless of their MDRO status, and Residents with a wound, regardless of their MDRO status. We will be posting signs on the doors of residents for whom EBP are recommended. The signs will also include reminders of the activities during which a gown and gloves should be worn. No policy regarding Enhanced Barrier Precautions was provided. 33198