STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical status for one (Resident #1) of four residents reviewed for physician notification. The physician/FNP were not notified that Resident #1 was restless on 04/16/24 on the night shift and was found with her face on the air mattress pump on the foot of the bed. This failure put residents at risk of delayed medical treatment. Findings include: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7441 Paseo Del Norte El Paso, TX 79911	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. 04/18/24 Levaquin 500 mg give 1 tablet by mouth at bedtime for UTI for 7 days. Review of Medication Administration Record (MAR) dated April 2024 for Resident #1 revealed, LVN B had not documented on 04/16/24 that she had adminstered Hydroxyzine HCL 25 mg give 50 mb by mouth every 6 hours as needed for anxiety. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 11, Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 1. Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's SBAR Communication Form dated 04/17/24 at 10:40 AM, written by the DON for Resident #1 revealed, Situation: This started on: 04/17/24. Bruise found on top of forehead. This condition, symptoms, or sign has occurred before: No. Resident is on another anticoagulant. Vital signs B/P: 112/53, Pulse: 69, RR: 16, Temp: 98.4 Fahrenheit Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation (compared to baseline; check all that you observed) Needs more assistance with ADL's. Swallowing difficulty, weakness (general). Pain Evaluation: Yes. Neurological Evaluation: Resident in hallway and nurse noticed bruise/hematoma to right top of forehead. Review and Notify: Appearance: Resident in hallway and noticed bruise/hematoma to right top of forehead. Primary Care Clinician Notified: Yes. Date: 04/17/24. Time: 10:30 AM. Recommendations: Send to ER for evaluation and treatment. Review of Resident #1's Progress Note dated 04/17/24 for Resident #1 written by the FNP revealed, patient found sitting in the hallway with other residents, is less interactive today and appears drowsy and somnolent, oriented only to person Patient presents with right forehead swelling and ecchymosis (a small bruise caused by blood vessels into the tissues of the skin or mucous membranes) that was found by morning nurse. It is unknown if the patient fell and hit her head, but swelling is significant, and patient is altered from her baseline mental status. No other swelling, redness, ecchymosis during head-to-toe assessment. Plan to send the patient to the emergency department emergently for stat head CT. Patient cognitively impaired. Diagnosis: Traumatic hematoma of head. Agitation. Review of Resident #1's Physician's Order dated 04/17/24 at 10:59 AM, written by the FNP revealed, may send to ED for further evaluation of hematoma to the right upper forehead and altered mental status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Emergency Department Encounter dated 04/17/24 at 12:13 PM revealed, Stated Complaint: Contusion .EMS. Chief Complaint: Head Pain/Injury. Patient's description of reason for visit: Pt. arrived via EMS after being called by Nursing Home for contusion found to right side of head. As reported to EMS, nursing home did not notice any symptoms related to trauma apart from contusion to head. Unwitnessed fall could have happened between 7:00 PM last night to 7:00 AM today. Objective assessment: Pt AAOx1 (name only). Chief Complaint: Head Pain. Pain intensity: 3. CT Brain w/o Contrast: 04/17/24 [AGE] years female, contusion. EMS; Head Contusion. Impression: Right frontal soft tissue hematoma without acute hemorrhage or extra-axial fluid collection (collection of blood or cerebrospinal fluid outside the brain and inner skull. CT Cervical Spine w/o contrast 04/17/24 Indication: [AGE] years female, contusion . EMS; Head Contusion. Impression: No acute abnormality of the cervical spine. Diagnosis: Head Contusion, UTI, and Pneumonia. Medications: Levaquin 500 mg orally daily for UTI/Pneumonia x 7 days 04/17/24 at 4:46 PM. Review of Resident #1's incident report dated 04/17/24 10:12 AM, for Resident #1 written by the DON revealed, resident was sitting in the hallway in her wheelchair and the nurse noted a bruise/hematoma to the right temple. There was a pinpoint red area in the middle of the hematoma. Asked resident if she fell , stated no but resident is Alert &Oriented to person and place. Observation on 04/18/24 at 9:19 PM, revealed Resident #1 was lying in bed, asleep. The resident's low bed was against the wall, with a floor mat, and air mattress in place. The air mattress pump was hung on the foot board. The resident had an oxygen cannula in place and was receiving 2 L/Min of oxygen. The resident had a hematoma on right side of forehead with fading light purple discoloration from the hair line down to the mid-forehead measuring approximately 3 cm x 3 cm. Interview on 04/18/24 at 9:20 PM, with LVN A revealed he had worked on 04/17/24 on the 6 AM-2 PM shift, and that the night nurse did not mention during report at the change of shift that Resident #1 had a change in condition. LVN A stated, Later during the shift, when I went to check [Resident #1's] blood pressure, is when I noticed that she had a hematoma on the right side of forehead. I immediately reported this to the DON, who was at the facility at that time. [Resident #1] was sent to the emergency room by EMS on 04/17/24 for evaluation and returned with a diagnosis of UTI, pneumonia, hematoma to right side of forehead. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 10:27 PM, with LVN B revealed she had worked on the night shift on 04/16/24 and was assigned to Resident #1. LVN B reported Resident #1 had not sustained a fall on her shift on that day. LVN B stated, On that day while I was making rounds at approximately 12 midnight, and I heard [Resident #1] making a lot of noise and was swearing. I went to the room and found Resident #1 lying in bed with her head on the foot of the bed. The right side of her face was against one of the metal hooks that hold the air mattress pump in place at the foot of the bed. Resident is confused, has incoherent speech and was not able to say what had happened. I called for help and [CNA C] came to the room to help me reposition the resident in bed. LVN B reported [Resident #1] was not able to stand without assistance. I administered Hydroxyzine to Resident #1 as ordered for anxiety that night because she was very restless and kept moving in bed. After the medication was administered, she slept the rest of the night on that day. I did not ask Resident #1 if she had sustained a fall on that day. I did not assess [Resident #1] on that day during the night shift since the resident had no apparent injury when she was repositioned in bed. LVN B reported she had not documented anything in the resident's clinical record on that day, since the resident did not have any apparent injuries when resident was moved from the foot of the bed to the head of the bed. I called the evening nurse and DON the next day on 04/17/24 to ask them if Resident #1 had sustained a fall in the morning or evening shift on 04/16/24 and both stated that the CNAs had not reported any falls on that day. At that time, the DON told me that Resident #1 was found in the morning on 04/17/24 with a hematoma to the right side of forehead. LVN B reported Resident #1 was very restless and moved constantly in bed and attempted to get out of bed without assistance. LVN B stated Resident #1 needed close supervision and re-direction to prevent falls. The nurse was not aware if the resident had a history of falls. Interview on 04/18/24 at 10:46 PM, CNA C revealed Resident #1 was confused, and only oriented to person. CNA C reported Resident #1 became combative and pushed staff away when attempts were made to provide care, and very restless while in bed and moved around in her bed. CNA C reported Resident #1 had not sustained any falls during the night shift on 04/16/24. CNA C reported the DON had sent him a text message on 04/17/24 asking him if Resident #1 had sustained a fall on the night shift on 04/16/24. CNA C stated, On 04/16/24 at approximately 10:30 - 11:00 PM, [LVN B] called me to the room to assist her to reposition [Resident #1] in bed. Upon entering the room, I noted Resident #1 had slid down in the bed and was in a fetal position. We pulled her up in bed using the draw sheet and did not see any visible injuries at that time. CNA C denied finding the resident at the foot of the bed with her face on the air mattress pump on that day as reported by LVN B. Interview on 04/18/24 at 10:57 PM, with the Administrator revealed the night nurse had reported to LVN A that she had found [Resident #1] with her head on the air mattress pump at the foot of the bed and had no visible injuries at that time. On 04/17/24 LVN A noted Resident #1 had a bump on the right side of her forehead and was sent to the hospital for a CT scan. Resident #1 was confused and was not able to say how she got the bump on the right side of her forehead. In an interview on 04/23/24 at 10:22 AM, with CNA D revealed she was assigned to Resident #1 on 04/17/24 on the morning shift. CNA D stated, I do not remember what time I got [Resident #1] out of bed on that day and sat her in her wheelchair to take her to the dining room for breakfast. I did not notice any injuries when I combed her hair. After breakfast, I heard that [LVN A] and the Med Aide had noted the bruise to the right side of forehead and was sent to the hospital for evaluation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 04/23/24 at 3:46 PM, with the DON revealed Resident #1 was sitting in her wheelchair in the hallway, when she arrived at the facility on 04/17/24 at approximately 7:30 AM on that day. The DON reported LVN A had noted the bruise on Resident #1's forehead on 04/17/24 at approximately 8:30 AM - 9:00 AM, when he was going to check the resident's blood pressure. The DON stated the FNP was in the facility making rounds at that time and was notified of the contusion to the right side of Resident #1's forehead and gave orders to send the resident by ambulance to the hospital for a CT scan of her head. The DON reported LVN B who worked on the night shift had reported she had found Resident #1 upside down, with her head on the foot of the bed. LVN B reported that the resident's head was on the metal hook that was used to hang the pressure mattress air pump from the foot of the bed. The night nurse reported the resident did not have any visible injuries at that time. In a telephone interview on 04/24/24 at 9:55 AM, the FNP revealed Resident #1 had been sent to the emergency department on 04/17/24 for evaluation of hematoma to the right side of her forehead and altered mental status. Resident #1 returned to the facility with a diagnosis of altered mental status, UTI, and pneumonia. Resident #1 was started on antibiotics and was getting oxygen. The FNP reported Resident #1 had a history of falls. The FNP stated the licensed staff should have reported to him on 04/16/24, that Resident #1 had been restless and moving in bed on the night shift and the Hydroxyzine was administered for anxiety. The FNP reported that he had arrived at the facility on 04/17/24 to make his routine rounds when LVN A had reported to him that he had noted Resident #1 had a contusion to the right side of her forehead and staff did not know how the resident had sustained the injury. The FNP stated that upon assessment on 04/17/24 Resident #1 was not at her baseline and he gave orders to send the resident to the emergency department for evaluation of altered mental status and contusion to the right side of her forehead. In a telephone interview on 04/23/24 at 10:39 AM, with LVN E revealed she had worked on the evening shift on 04/16/24 and Resident #1 had not had any falls or injuries during her shift. LVN E stated, I received a text message from [LVN B] that works on the night shift on 04/17/24 at 7:20 PM, asking if [Resident #1] had sustained a fall yesterday, because the day nurse had asked her if she had seen the bump on the resident's head. LVN B said that she had noticed anything on the night shift on 04/16/24 when she had given her the Hydroxyzine for anxiety. Interview and record review on 04/23/24 at 5:49 PM, with the DON facility's undated policy & procedure on Notification of Changes in Condition provided by the DON revealed, Policy: The purpose of this policy is to ensure the facility promptly informs, consults the resident's physician; and notifies, consistent with is or her authority, the resident's representative where there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician, the resident's family member or legal representative when there is a change requiring such notifications.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interview and record review the facility failed to implement written policies that prohibit and abuse, neglect, and exploitation of residents and to investigate any such allegations for two (Resident #1 and Resident #2) of 4 residents reviewed for implementation of written abuse, neglect, and exploitation policies: The facility failed to follow the facility policy on reporting allegations of all alleged violations to the Administrator, State agency and other officials in accordance with state law on and to investigate any such allegations on; -04/17/24 when Resident # 1 was found with a hematoma to right side of forehead of unknown origin. -04/05/24 when Resident # 2 was found with a hematoma to ghe forehead of unknown origin. This failure could place all residents at the facility at risk for abuse. Findings included: Review of facility's undated policy & procedure on Abuse, Neglect, and Exploitation provided by Administrator on 04/18/24 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitaion and misappropriation of resident property. Policy Explanation and Compliance Guidelines: The facility will develop and implement written policies and procedure that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations; The facility will designate an Abuse Prohibition Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Investigation of Alleged Abuse, Neglect and Exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Providing complete and through documentation of the investigation. Reporting/Response: The facility will have written policies the include: Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. Review of Resident #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. 04/18/24 Levaquin 500 mg give 1 tablet by mouth at bedtime for UTI for 7 days. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 11, Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 1. Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's SBAR Communication Form dated 04/17/24 at 10:40 AM, written by the DON for Resident #1 revealed, Situation: This started on: 04/17/24. Bruise found on top of forehead. This condition, symptoms, or sign has occurred before: No. Resident is on another anticoagulant. Vital signs B/P: 112/53, Pulse: 69, RR: 16, Temp: 98.4 Fahrenheit Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation (compared to baseline; check all that you observed) Needs more assistance with ADL's. Swallowing difficulty, weakness (general). Pain Evaluation: Yes. Neurological Evaluation: Resident in hallway and nurse noticed bruise/hematoma to right top of forehead. Review and Notify: Appearance: Resident in hallway and noticed bruise/hematoma to right top of forehead. Primary Care Clinician Notified: Yes. Date: 04/17/24. Time: 10:30 AM. Recommendations: Send to ER for evaluation and treatment. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Progress Note dated 04/17/24 for Resident #1 written by the FNP revealed, patient found sitting in the hallway with other residents, is less interactive today and appears drowsy and somnolent, oriented only to person Patient presents with right forehead swelling and ecchymosis (a small bruise caused by blood vessels into the tissues of the skin or mucous membranes) that was found by morning nurse. It is unknown if the patient fell and hit her head, but swelling is significant, and patient is altered from her baseline mental status. No other swelling, redness, ecchymosis during head-to-toe assessment. Plan to send the patient to the emergency department emergently for stat head CT. Patient cognitively impaired. Diagnosis: Traumatic hematoma of head. Agitation. Review of Resident #1's Physician's Order dated 04/17/24 at 10:59 AM, written by the FNP revealed, may send to ED for further evaluation of hematoma to the right upper forehead and altered mental status. Review of Resident #1's Emergency Department Encounter dated 04/17/24 at 12:13 PM revealed, Stated Complaint: Contusion .EMS. Chief Complaint: Head Pain/Injury. Patient's description of reason for visit: Pt. arrived via EMS after being called by Nursing Home for contusion found to right side of head. As reported to EMS, nursing home did not notice any symptoms related to trauma apart from contusion to head. Unwitnessed fall could have happened between 7:00 PM last night to 7:00 AM today. Objective assessment: Pt AAOx1 (name only). Chief Complaint: Head Pain. Pain intensity: 3. CT Brain w/o Contrast: 04/17/24 [AGE] years female, contusion. EMS; Head Contusion. Impression: Right frontal soft tissue hematoma without acute hemorrhage or extra-axial fluid collection (collection of blood or cerebrospinal fluid outside the brain and inner skull. CT Cervical Spine w/o contrast 04/17/24 Indication: [AGE] years female, contusion . EMS; Head Contusion. Impression: No acute abnormality of the cervical spine. Diagnosis: Head Contusion, UTI, and Pneumonia. Medications: Levaquin 500 mg orally daily for UTI/Pneumonia x 7 days 04/17/24 at 4:46 PM. Review of Resident #1's incident report dated 04/17/24 10:12 AM, for Resident #1 written by the DON revealed, resident was sitting in the hallway in her wheelchair and the nurse noted a bruise/hematoma to the right temple. There was a pinpoint red area in the middle of the hematoma. Asked resident if she fell , stated no but resident is Alert &Oriented to person and place. Record review of TULIP (computer software that tracks incident/complaint intakes reported to state office) revealed no self-report for Resident #1's injury of unknown origin to the right side of her forehead. Observation on 04/18/24 at 9:19 PM, revealed Resident #1 was lying in bed, asleep. The resident's low bed was against the wall, with a floor mat, and air mattress in place. The air mattress pump was hung on the foot board. The resident had an oxygen cannula in place and was receiving 2 L/Min of oxygen. The resident had a hematoma on right side of forehead with fading light purple discoloration from the hair line down to the mid-forehead measuring approximately 3 cm x 3 cm. Interview on 04/18/24 at 9:20 PM, with LVN A revealed he had worked on 04/17/24 on the 6 AM-2 PM shift, and that the night nurse did not mention during report at the change of shift that Resident #1 had a change in condition. LVN A stated, Later during the shift, when I went to check [Resident #1's] blood pressure, is when I noticed that she had a hematoma on the right side of forehead. I immediately reported this to the DON, who was at the facility at that time. [Resident #1] was sent to the emergency room by EMS on 04/17/24 for evaluation and returned with a diagnosis of UTI, pneumonia, hematoma to right side of forehead. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7441 Paseo Del Norte El Paso, TX 79911	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 10:27 PM, with LVN B revealed she had worked on the night shift on 04/16/24 and was assigned to Resident #1. LVN B reported Resident #1 had not sustained a fall on her shift on that day. LVN B stated, On that day while I was making rounds at approximately 12 midnight, and I heard [Resident #1] making a lot of noise and was swearing. I went to the room and found Resident #1 lying in bed with her head on the foot of the bed. The right side of her face was against one of the metal hooks that hold the air mattress pump in place at the foot of the bed. Resident is confused, has incoherent speech and was not able to say what had happened. I called for help and [CNA C] came to the room to help me reposition the resident in bed. LVN B reported [Resident #1] was not able to stand without assistance. I administered Hydroxyzine to Resident #1 as ordered for anxiety that night because she was very restless and kept moving in bed. After the medication was administered, she slept the rest of the night on that day. I did not ask Resident #1 if she had sustained a fall on that day. I did not assess [Resident #1] on that day during the night shift since the resident had no apparent injury when she was repositioned in bed. LVN B reported she had not documented anything in the resident's clinical record on that day, since the resident did not have any apparent injuries when resident was moved from the foot of the bed to the head of the bed. I called the evening nurse and DON the next day on 04/17/24 to ask them if Resident #1 had sustained a fall in the morning or evening shift on 04/16/24 and both stated that the CNAs had not reported any falls on that day. At that time, the DON told me that Resident #1 was found in the morning on 04/17/24 with a hematoma to the right side of forehead. LVN B reported Resident #1 was very restless and moved constantly in bed and attempted to get out of bed without assistance. LVN B stated Resident #1 needed close supervision and re-direction to prevent falls. The nurse was not aware if the resident had a history of falls. Interview on 04/18/24 at 10:46 PM, CNA C revealed Resident #1 was confused, and only oriented to person. CNA C reported Resident #1 became combative and pushed staff away when attempts were made to provide care, and very restless while in bed and moved around in her bed. CNA C reported Resident #1 had not sustained any falls during the night shift on 04/16/24. CNA C reported the DON had sent him a text message on 04/17/24 asking him if Resident #1 had sustained a fall on the night shift on 04/16/24. CNA C stated, On 04/16/24 at approximately 10:30 - 11:00 PM, [LVN B] called me to the room to assist her to reposition [Resident #1] in bed. Upon entering the room, I noted Resident #1 had slid down in the bed and was in a fetal position. We pulled her up in bed using the draw sheet and did not see any visible injuries at that time. CNA C denied finding the resident at the foot of the bed with her face on the air mattress pump on that day as reported by LVN B. Interview on 04/18/24 at 10:57 PM, with the Administrator revealed the night nurse had reported to LVN A that she had found [Resident #1] with her head on the air mattress pump at the foot of the bed and had no visible injuries at that time. On 04/17/24 LVN A noted Resident #1 had a bump on the right side of her forehead and was sent to the hospital for a CT scan. Resident #1 was confused and was not able to say how she got the bump on the right side of her forehead. The Administrator reported that the incident had not been reported to state office, because they went by what was reported by LVN B. In an interview on 04/23/24 at 10:22 AM, with CNA D revealed she was assigned to Resident #1 on 04/17/24 on the morning shift. CNA D stated, I do not remember what time I got [Resident #1] out of bed on that day and sat her in her wheelchair to take her to the dining room for breakfast. I did not notice any injuries when I combed her hair. After breakfast, I heard that [LVN A] and the Med Aide had noted the bruise to the right side of forehead and was sent to the hospital for evaluation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 04/23/24 at 3:46 PM, with the DON revealed Resident #1 was sitting in her wheelchair in the hallway, when she arrived at the facility on 04/17/24 at approximately 7:30 AM on that day. The DON reported LVN A had noted the bruise on Resident #1's forehead on 04/17/24 at approximately 8:30 AM - 9:00 AM, when he was going to check the resident's blood pressure. The DON stated the FNP was in the facility making rounds at that time and was notified of the contusion to the right side of Resident #1's forehead and gave orders to send the resident by ambulance to the hospital for a CT scan of her head. The DON reported LVN B who worked on the night shift had reported she had found Resident #1 upside down, with her head on the foot of the bed. LVN B reported that the resident's head was on the metal hook that was used to hang the pressure mattress air pump from the foot of the bed. The night nurse reported the resident did not have any visible injuries at that time. The Administrator decides when to report incidents to state office. The DON, stated, We did not consider this to be an injury of unknown origin because of how she was found at night in her bed with her head against the metal hook where the air mattress pump was attached. I guess that is how we weighed the situation. We did not investigate the injury, because we went by what the night nurse had reported to LVN A. DON, confirmed Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. DON stated that according to the Provider Letter the incidents for Resident #1 and Resident #2 should have been classified as injuries of unknown origin and should have been reported to state office since the residents were not able to explain how they got injured and there were no witnesses to the incidents. The DON stated, The Administrator I did not think that the incidents involving [Resident #1] and [Resident #2] were reportable based on what was reported by the nurses assigned to the residents. However, after reading the provider letter, we should have reported this incident to state office. In a telephone interview on 04/24/24 at 9:55 AM, the FNP revealed Resident #1 had been sent to the emergency department on 04/17/24 for evaluation of hematoma to the right side of her forehead and altered mental status. Resident #1 returned to the facility with a diagnosis of altered mental status, UTI, and pneumonia. Resident #1 was started on antibiotics and was getting oxygen. The FNP reported Resident #1 had a history of falls. The FNP stated the licensed staff should have reported to him on 04/16/24, that Resident #1 had been restless and moving in bed on the night shift and the Hydroxyzine was administered for anxiety. The FNP reported that he had arrived at the facility on 04/17/24 to make his routine rounds when LVN A had reported to him that he had noted Resident #1 had a contusion to the right side of her forehead and staff did not know how the resident had sustained the injury. The FNP stated that upon assessment on 04/17/24 Resident #1 was not at her baseline and he gave orders to send the resident to the emergency department for evaluation of altered mental status and contusion to the right side of her forehead. In a telephone interview on 04/23/24 at 10:39 AM, with LVN E revealed she had worked on the evening shift on 04/16/24 and Resident #1 had not had any falls or injuries during her shift. LVN E stated, I received a text message from [LVN B] that works on the night shift on 04/17/24 at 7:20 PM, asking if [Resident #1] had sustained a fall yesterday, because the day nurse had asked her if she had seen the bump on the resident's head. LVN B said that she had noticed anything on the night shift on 04/16/24 when she had given her the Hydroxyzine for anxiety. Resident #2 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Admission Record dated 04/23/24 at 3:06 PM, revealed admitted : 09/12/2020. admitted from hospital. Review of Medical Visit dated 04/15/2024 at 12:09 PM, History: Resident #2 revealed, [AGE] year-old female seen today for a Hospice follow-up visit. History of Present Illness: During this visit the patient was found to have a large bruise to her forehead and bilateral (both) eye orbits, per nursing reports the patient hit herself with the closing door. The patient continues under the care of Hospice of El Paso for terminal Chronic Obstructive Pulmonary Disease. Past Medical History: Alzheimer Dementia, Generalize anxiety, Major depressive disorder. Review of the MDS Quarterly Assessment, dated 01/26/2024 for Resident #2 revealed, hearing adequate; Clear speech; Rarely makes self-Understood; Rarely understands others; Vision Adequate; BIMS-score 0 (severely impaired); Acute onset Mental Status Change-Inattention, Disorganized Thinking; Behaviors: Physical Aggression-Behaviors of this type occurred 1 to 3 days. Verbal Aggression-Behaviors of this type occurred 1 to 3 days. Other behavioral symptoms not directed toward others-Behaviors of this type occurred 1 to 3 days. Rejection of Care Behaviors of this type occurred 1 to 3 days. Functional Limitation in Range of Motion: Impairment on one side - upper extremity. Impairment on both sides - lower extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, Oral hygiene dependent, toileting dependent, shower dependent, upper body dressing dependent, personal hygiene-dependent; lower body dressing substantial assistance. Mobility: Roll left and right-dependent; Sit to lying-dependent; Lying to sitting on side of bed-dependent; Sit to stand-dependent; Chair/bed transfer-dependent; Toilet transfer-dependent; shower-dependent; incontinent of bowel & bladder; Medications-Antidepressant, Antiplatelet; Hospice Care; Occupational Therapy. Review of the Care Plan revised 12/14/2021, for Resident #2 revealed, Cognitive Impairment r/t Alzheimer Dementia, impaired ability to make decisions, difficulty in expressing needs, impaired safety awareness. Potential for Injury r/t Actual falls, noncompliance with safety interventions, cognitive impairment, impaired safety-revised 06/12/2022. Require assistance with ADLs r/t cognitive deficits revised 08/01/2023. Potential for alteration in bleeding tendencies and increase bruising r/t use of anticoagulant/antiplatelet Aspirin revised 12/15/2021. Resident receiving Hospice Services r/t terminal disease COPD revised 07/21/2022. Episodes of adverse behaviors: Verbally aggressive-cursing, racial slurs, yelling/screaming; physically aggressive hitting staff or residents. Review of an Incident Report dated 04/05/2024 2:00 PM, written by LVN F for Resident #2 revealed, Resident #2 was agitated and aggressive this morning. After lunch time the resident presented with a hematoma to her forehead. The resident was in her room going through her personal belongings and the roommate's drawers and closets. The resident was transferred to bed and the CNA reported the resident's status. Head to toe assessment. The hospice provider was notified. The family member was notified. The MD was notified. The resident had a hematoma to face the size of an egg. Predisposing Physiological Factors-confused and impaired memory. Witnesses: No witnesses found. Review of Nursing Progress Note dated 04/07/2024 6:46 PM, written by the DON, for Resident #2 revealed, LATE ENTRY: This nurse was on phone video after permission obtained. This nurse noted bruise from top of hematoma down the right side of face to chin. It appears that the bruise had dissipated. Resident was in bed at time of assessment. Able to lift head. Charge nurse stated that the resident was up in chair for meals, and she was at baseline. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 04/07/2024 7:07 PM, written by LVN F for Resident #2 revealed, called hospice regarding hematoma to her forehead. Review of the Physician's Order dated 04/08/2024, provided by the DON for Resident #2 revealed, send resident to hospital via ambulance for a CT scan of the head. Review of the Nursing Progress Note dated 04/08/2024 11:30 AM, written by LVN G, for Resident #2 revealed, resident was picked up via ambulance to be transported to hospital to get CT scan of head and facial x-rays due to hematoma and scattered bruising to her face. The family and DON were contacted about transport. Review of CT Head Final Report dated 04/08/2024 1:23 PM, provided by the DON for Resident #2 revealed, Reason for Exam: Female, 99-years-old. Trauma. Findings: A right forehead scalp 1.5 x 2 cm diameter by 0. 9 cm thickness hematoma is seen. There is no intracranial hemorrhage. Impression: Right forehead scalp hematoma. Review of Resident #2's Medical Visit dated 04/15/2024 at 12:09 PM revealed the resident was found to have a large bruise to her forehead and bilateral (both) eye orbits. Per nursing reports the patient hit herself with the closing door. The patient continues under the care of hospice for terminal COPD. Past Medical History: Alzheimer Dementia, hypertension, HLD, Atrial Fibrillation, Hypothyroidism, Generalize anxiety, Major depressive disorder. Review of the Medication Administration Record dated April 04/01/24 - 04/30/2024, for Resident #2 revealed, Aspirin 81 mg give one tablet by mouth one time daily for PPX (Prophylaxis). Lorazepam Oral Concentrate 1 mg/0.5 ml give 1 mg by mouth evert 4 hours as needed for mild anxiety. Lorazepam Oral Concentrate 1 mg/0.5 ml give 2 mg by mouth evert 4 hours as needed for severe anxiety. In an interview on 04/23/24 at 3:24 PM, the DON stated, she did not recall if Resident #2 had been sent to the emergency room for a CT scan of the head. The DON stated, Let me check. An observation on 04/23/24 at 4:37 PM, revealed Resident #2 was sitting in a wheelchair in the hallway by the entrance to her room. The resident was oriented to her name and did not respond to simple questions. It was observed that Resident #2 had a fading, very light purple bruising to bilateral eyes, cheeks, and her nose. In a telephone interview on 04/24/24 at 10:34 AM, with Resident #2's family member revealed the staff reported they had found Resident #2 with a bump to her head. The origin of injury was unknown. The staff initially reported that Resident #2 had hit her head on the bed and then they kept changing the story. LVN F did not report the bump on the head to the DON and nothing was done about it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 11:22 AM, with the family member for Resident #2 revealed staff had reported to her that Resident #2 was pulling things from drawers/closets and maybe she had hit herself with the drawers or closet doors. On Friday 04/05/24 at breakfast, Resident #2 was throwing food, staff took her to her room and put her in bed. The staff reported that during rounds, they had noted the bruise to her face on 04/05/24. On Saturday 04/06/24 the family member reported she went to visit Resident #2 and noted purple bruises around her eyes. On Sunday 04/07/24 the family member reported she went to visit Resident #2 and found her sitting in her wheelchair, and her face was all purple. The family member reported she took the resident to the head nurse to see what they had done to address the bruising to her face. Resident #2 was sent on Monday 04/08/24 to hospital ambulance for a CT scan of the face. In an observation and interview on 04/24/24 at 11:33 PM, with LVN F on the day shift, revealed Resident #2 was in her room sitting in a wheelchair. The resident did not answer simple questions. It was observed the resident had fading, light purple bruising around the eye orbits down to her cheeks. LVN F stated, I was working on 04/05/24, when Resident #2 was found with the bump on her forehead the size of a quarter. The bump to her head was noted at approximately 1:30 PM on that day by the therapist. No other injuries were noted at the time of the assessment. LVN F reported that he and CNA H had seen Resident #2 forcefully opening & closing the closet doors and dresser drawers in her room and going through the dresser drawers. LVN F reported that on that day Resident #2 was agitated and was cursing. LVN F stated, I was working in the decentralized nurses' station that is close to Resident #2's room, and I heard loud banging of drawers, closet doors, and loud yelling. I went to the room to check and see if the Resident # 2 was OK. The door to the room was opened. It was already the end of the shift, and I was making the last round. CNA H was in the room attempting to calm down Resident #2. LVN F, stated, I assumed that Resident #2 got hit with the closet door on the face. The resident was not able to tell me what had happened. The resident was sitting in her wheelchair, was calm, and smiling at me. I assessed the resident and did not see any injuries at time of assessment. In an observation and interview on 04/24/24 at 12:03 PM, with CNA H, revealed that she worked on 04/05/24 on the morning shift and after breakfast heard someone yelling loudly and making a lot of noise. CNA stated, I walked down the hall and noticed the noise was coming from Resident #2's room. When I entered Resident #2's room she was by the window forcefully opening and forcefully closing the closet doors. The resident was also forcefully opening and closing the dresser drawers. The dresser drawers would bounce back and would slightly open when closed. I did not see resident get hit by the dresser drawers or the closet doors on that day. CNA H reported that she had left the room to allow [Resident #1] to calm down and went to report LVN F. CNA stated, In the evening, I was at the decentralized nurse's station feeding a resident when I saw one of the therapist's came to report to LVN F that Resident #2 had a bruise on forehead. I went to check the resident before the end of the shift and noted that she had a bruise on the forehead and down to the bridge of the nose. The next day when I returned to work on 04/06/24 on the day shift and noted Resident #2 had dark purple bruising on both eyes and on her cheeks. I remember that on that day, the hospice nurse came to see the resident. CNA H reported Resident #2 would take the clothes from the drawers and mix her clothes in her room mate's drawers and frequently refused care. CNA H stated they had been trained to report any behaviors immediately to the nurses. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 5:59 PM with the COTA, revealed [Resident #2] was on hospice and was receiving occupational therapy. The COTA stated, I remember that on that day 04/05/24, I had not finished my therapy session and went later that afternoon to complete the therapy session. I wrote in my therapy notes that upon entering the room, I had noted [Resident #2] had a bruise on the forehead and immediately went to report this to LVN F on the morning shift. LVN F came to the room assessed the resident and said, it was a vein and not a bruise. The COTA agreed to email the surveyor a copy of the notes for 04/05/24. The therapy note was not emailed to the surveyor prior to exit on 04/24/24. In an interview and record review on 04/23/24 at 3:36 PM, with the Administer revealed a Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. Incidents that a NF Must Report to HHSC and the Time Frames for Reporting. A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Suspicious injuries of unknown source. Injuries of unknown source: Note: an injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. The Administrator stated, I did not think that the incidents involving Resident #1 and Resident #2 were reportable. However, after reading the provider letter, we should have reported these two incidents to state office and investigated the cause of injury.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based observation, interviews and record reviews the facility failed to ensure all alleged violations which involved abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for 2 of 4 Residents (Residents #1, and #2) reviewed for injuries of unknown origin. 1. The facility failed to ensure staff reported to the Administrator and or the state agency on 04/17/24 when Resident #1 was found with a hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space) to the right side of her forehead and the cause of injury was unknown. 2. The facility failed to ensure staff reported to the Administrator and or the state agency on 04/05/24 when Resident #2 was found with a hematoma to her forehead and the cause of injury was unknown. These deficient practices could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment. Findings include: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Resident #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. 04/18/24 Levaquin 500 mg give 1 tablet by mouth at bedtime for UTI for 7 days.

Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 11, Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present.

Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 1. Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present.

Review of Resident #1's SBAR Communication Form dated 04/17/24 at 10:40 AM, written by the DON for Resident #1 revealed, Situation: This started on: 04/17/24. Bruise found on top of forehead. This condition, symptoms, or sign has occurred before: No. Resident is on another anticoagulant. Vital signs B/P: 112/53, Pulse: 69, RR: 16, Temp: 98.4 Fahrenheit Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation (compared to baseline; check all that you observed) Needs more assistance with ADL's. Swallowing difficulty, weakness (general). Pain Evaluation: Yes. Neurological Evaluation: Resident in hallway and nurse noticed bruise/hematoma to right top of forehead. Review and Notify: Appearance: Resident in hallway and noticed bruise/hematoma to right top of forehead. Primary Care Clinician Notified: Yes. Date: 04/17/24. Time: 10:30 AM. Recommendations: Send to ER for evaluation and treatment.

Review of Resident #1's Progress Note dated 04/17/24 for Resident #1 written by the FNP revealed, patient found sitting in the hallway with other residents, is less interactive today and appears drowsy and somnolent, oriented only to person Patient presents with right forehead swelling and ecchymosis (a small bruise caused by blood vessels into the tissues of the skin or mucous membranes) that was found by morning nurse. It is unknown if the patient fell and hit her head, but swelling is significant, and patient is altered from her baseline mental status. No other swelling, redness, ecchymosis during head-to-toe assessment. Plan to send the patient to the emergency department emergently for stat head CT. Patient cognitively impaired. Diagnosis: Traumatic hematoma of head. Agitation.

Review of Resident #1's Physician's Order dated 04/17/24 at 10:59 AM, written by the FNP revealed, may send to ED for further evaluation of hematoma to the right upper forehead and altered mental status.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7441 Paseo Del Norte El Paso, TX 79911	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Emergency Department Encounter dated 04/17/24 at 12:13 PM revealed, Stated Complaint: Contusion .EMS. Chief Complaint: Head Pain/Injury. Patient's description of reason for visit: Pt. arrived via EMS after being called by Nursing Home for contusion found to right side of head. As reported to EMS, nursing home did not notice any symptoms related to trauma apart from contusion to head. Unwitnessed fall could have happened between 7:00 PM last night to 7:00 AM today. Objective assessment: Pt AAOx1 (name only). Chief Complaint: Head Pain. Pain intensity: 3. CT Brain w/o Contrast: 04/17/24 [AGE] years female, contusion. EMS; Head Contusion. Impression: Right frontal soft tissue hematoma without acute hemorrhage or extra-axial fluid collection (collection of blood or cerebrospinal fluid outside the brain and inner skull. CT Cervical Spine w/o contrast 04/17/24 Indication: [AGE] years female, contusion . EMS; Head Contusion. Impression: No acute abnormality of the cervical spine. Diagnosis: Head Contusion, UTI, and Pneumonia. Medications: Levaquin 500 mg orally daily for UTI/Pneumonia x 7 days 04/17/24 at 4:46 PM. Review of Resident #1's incident report dated 04/17/24 10:12 AM, for Resident #1 written by the DON revealed, resident was sitting in the hallway in her wheelchair and the nurse noted a bruise/hematoma to the right temple. There was a pinpoint red area in the middle of the hematoma. Asked resident if she fell , stated no but resident is Alert &Oriented to person and place. Record review of TULIP (computer software that tracks incident/complaint intakes reported to state office) revealed no self-report for Resident #1's injury of unknown origin to the right side of her forehead. Observation on 04/18/24 at 9:19 PM, revealed Resident #1 was lying in bed, asleep. The resident's low bed was against the wall, with a floor mat, and air mattress in place. The air mattress pump was hung on the foot board. The resident had an oxygen cannula in place and was receiving 2 L/Min of oxygen. The resident had a hematoma on right side of forehead with fading light purple discoloration from the hair line down to the mid-forehead measuring approximately 3 cm x 3 cm. Interview on 04/18/24 at 9:20 PM, with LVN A revealed he had worked on 04/17/24 on the 6 AM-2 PM shift, and that the night nurse did not mention during report at the change of shift that Resident #1 had a change in condition. LVN A stated, Later during the shift, when I went to check [Resident #1's] blood pressure, is when I noticed that she had a hematoma on the right side of forehead. I immediately reported this to the DON, who was at the facility at that time. [Resident #1] was sent to the emergency room by EMS on 04/17/24 for evaluation and returned with a diagnosis of UTI, pneumonia, hematoma to right side of forehead. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 10:27 PM, with LVN B revealed she had worked on the night shift on 04/16/24 and was assigned to Resident #1. LVN B reported Resident #1 had not sustained a fall on her shift on that day. LVN B stated, On that day while I was making rounds at approximately 12 midnight, and I heard [Resident #1] making a lot of noise and was swearing. I went to the room and found Resident #1 lying in bed with her head on the foot of the bed. The right side of her face was against one of the metal hooks that hold the air mattress pump in place at the foot of the bed. Resident is confused, has incoherent speech and was not able to say what had happened. I called for help and [CNA C] came to the room to help me reposition the resident in bed. LVN B reported [Resident #1] was not able to stand without assistance. I administered Hydroxyzine to Resident #1 as ordered for anxiety that night because she was very restless and kept moving in bed. After the medication was administered, she slept the rest of the night on that day. I did not ask Resident #1 if she had sustained a fall on that day. I did not assess [Resident #1] on that day during the night shift since the resident had no apparent injury when she was repositioned in bed. LVN B reported she had not documented anything in the resident's clinical record on that day, since the resident did not have any apparent injuries when resident was moved from the foot of the bed to the head of the bed. I called the evening nurse and DON the next day on 04/17/24 to ask them if Resident #1 had sustained a fall in the morning or evening shift on 04/16/24 and both stated that the CNAs had not reported any falls on that day. At that time, the DON told me that Resident #1 was found in the morning on 04/17/24 with a hematoma to the right side of forehead. LVN B reported Resident #1 was very restless and moved constantly in bed and attempted to get out of bed without assistance. LVN B stated Resident #1 needed close supervision and re-direction to prevent falls. The nurse was not aware if the resident had a history of falls. Interview on 04/18/24 at 10:46 PM, CNA C revealed Resident #1 was confused, and only oriented to person. CNA C reported Resident #1 became combative and pushed staff away when attempts were made to provide care, and very restless while in bed and moved around in her bed. CNA C reported Resident #1 had not sustained any falls during the night shift on 04/16/24. CNA C reported the DON had sent him a text message on 04/17/24 asking him if Resident #1 had sustained a fall on the night shift on 04/16/24. CNA C stated, On 04/16/24 at approximately 10:30 - 11:00 PM, [LVN B] called me to the room to assist her to reposition [Resident #1] in bed. Upon entering the room, I noted Resident #1 had slid down in the bed and was in a fetal position. We pulled her up in bed using the draw sheet and did not see any visible injuries at that time. CNA C denied finding the resident at the foot of the bed with her face on the air mattress pump on that day as reported by LVN B. Interview on 04/18/24 at 10:57 PM, with the Administrator revealed the night nurse had reported to LVN A that she had found [Resident #1] with her head on the air mattress pump at the foot of the bed and had no visible injuries at that time. On 04/17/24 LVN A noted Resident #1 had a bump on the right side of her forehead and was sent to the hospital for a CT scan. Resident #1 was confused and was not able to say how she got the bump on the right side of her forehead. The Administrator reported that the incident had not been reported to state office, because they went by what was reported by LVN B. In an interview on 04/23/24 at 10:22 AM, with CNA D revealed she was assigned to Resident #1 on 04/17/24 on the morning shift. CNA D stated, I do not remember what time I got [Resident #1] out of bed on that day and sat her in her wheelchair to take her to the dining room for breakfast. I did not notice any injuries when I combed her hair. After breakfast, I heard that [LVN A] and the Med Aide had noted the bruise to the right side of forehead and was sent to the hospital for evaluation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 04/23/24 at 3:46 PM, with the DON revealed Resident #1 was sitting in her wheelchair in the hallway, when she arrived at the facility on 04/17/24 at approximately 7:30 AM on that day. The DON reported LVN A had noted the bruise on Resident #1's forehead on 04/17/24 at approximately 8:30 AM - 9:00 AM, when he was going to check the resident's blood pressure. The DON stated the FNP was in the facility making rounds at that time and was notified of the contusion to the right side of Resident #1's forehead and gave orders to send the resident by ambulance to the hospital for a CT scan of her head. The DON reported LVN B who worked on the night shift had reported she had found Resident #1 upside down, with her head on the foot of the bed. LVN B reported that the resident's head was on the metal hook that was used to hang the pressure mattress air pump from the foot of the bed. The night nurse reported the resident did not have any visible injuries at that time. The Administrator decides when to report incidents to state office. The DON, stated, We did not consider this to be an injury of unknown origin because of how she was found at night in her bed with her head against the metal hook where the air mattress pump was attached. I guess that is how we weighed the situation. We did not investigate the injury, because we went by what the night nurse had reported to LVN A. DON, confirmed Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. DON stated that according to the Provider Letter the incidents for Resident #1 and Resident #2 should have been classified as injuries of unknown origin and should have been reported to state office since the residents were not able to explain how they got injured and there were no witnesses to the incidents. The DON stated, The Administrator I did not think that the incidents involving [Resident #1] and [Resident #2] were reportable based on what was reported by the nurses assigned to the residents. However, after reading the provider letter, we should have reported this incident to state office. In a telephone interview on 04/24/24 at 9:55 AM, the FNP revealed Resident #1 had been sent to the emergency department on 04/17/24 for evaluation of hematoma to the right side of her forehead and altered mental status. Resident #1 returned to the facility with a diagnosis of altered mental status, UTI, and pneumonia. Resident #1 was started on antibiotics and was getting oxygen. The FNP reported Resident #1 had a history of falls. The FNP stated the licensed staff should have reported to him on 04/16/24, that Resident #1 had been restless and moving in bed on the night shift and the Hydroxyzine was administered for anxiety. The FNP reported that he had arrived at the facility on 04/17/24 to make his routine rounds when LVN A had reported to him that he had noted Resident #1 had a contusion to the right side of her forehead and staff did not know how the resident had sustained the injury. The FNP stated that upon assessment on 04/17/24 Resident #1 was not at her baseline and he gave orders to send the resident to the emergency department for evaluation of altered mental status and contusion to the right side of her forehead. In a telephone interview on 04/23/24 at 10:39 AM, with LVN E revealed she had worked on the evening shift on 04/16/24 and Resident #1 had not had any falls or injuries during her shift. LVN E stated, I received a text message from [LVN B] that works on the night shift on 04/17/24 at 7:20 PM, asking if [Resident #1] had sustained a fall yesterday, because the day nurse had asked her if she had seen the bump on the resident's head. LVN B said that she had noticed anything on the night shift on 04/16/24 when she had given her the Hydroxyzine for anxiety. Resident #2 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Admission Record dated 04/23/24 at 3:06 PM, revealed admitted : 09/12/2020. admitted from hospital. Review of Medical Visit dated 04/15/2024 at 12:09 PM, History: Resident #2 revealed, [AGE] year-old female seen today for a Hospice follow-up visit. History of Present Illness: During this visit the patient was found to have a large bruise to her forehead and bilateral (both) eye orbits, per nursing reports the patient hit herself with the closing door. The patient continues under the care of Hospice of El Paso for terminal Chronic Obstructive Pulmonary Disease. Past Medical History: Alzheimer Dementia, Generalize anxiety, Major depressive disorder. Review of the MDS Quarterly Assessment, dated 01/26/2024 for Resident #2 revealed, hearing adequate; Clear speech; Rarely makes self-Understood; Rarely understands others; Vision Adequate; BIMS-score 0 (severely impaired); Acute onset Mental Status Change-Inattention, Disorganized Thinking; Behaviors: Physical Aggression-Behaviors of this type occurred 1 to 3 days. Verbal Aggression-Behaviors of this type occurred 1 to 3 days. Other behavioral symptoms not directed toward others-Behaviors of this type occurred 1 to 3 days. Rejection of Care Behaviors of this type occurred 1 to 3 days. Functional Limitation in Range of Motion: Impairment on one side - upper extremity. Impairment on both sides - lower extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, Oral hygiene dependent, toileting dependent, shower dependent, upper body dressing dependent, personal hygiene-dependent; lower body dressing substantial assistance. Mobility: Roll left and right-dependent; Sit to lying-dependent; Lying to sitting on side of bed-dependent; Sit to stand-dependent; Chair/bed transfer-dependent; Toilet transfer-dependent; shower-dependent; incontinent of bowel & bladder; Medications-Antidepressant, Antiplatelet; Hospice Care; Occupational Therapy. Review of the Care Plan revised 12/14/2021, for Resident #2 revealed, Cognitive Impairment r/t Alzheimer Dementia, impaired ability to make decisions, difficulty in expressing needs, impaired safety awareness. Potential for Injury r/t Actual falls, noncompliance with safety interventions, cognitive impairment, impaired safety-revised 06/12/2022. Require assistance with ADLs r/t cognitive deficits revised 08/01/2023. Potential for alteration in bleeding tendencies and increase bruising r/t use of anticoagulant/antiplatelet Aspirin revised 12/15/2021. Resident receiving Hospice Services r/t terminal disease COPD revised 07/21/2022. Episodes of adverse behaviors: Verbally aggressive-cursing, racial slurs, yelling/screaming; physically aggressive hitting staff or residents. Review of an Incident Report dated 04/05/2024 2:00 PM, written by LVN F for Resident #2 revealed, Resident #2 was agitated and aggressive this morning. After lunch time the resident presented with a hematoma to her forehead. The resident was in her room going through her personal belongings and the roommate's drawers and closets. The resident was transferred to bed and the CNA reported the resident's status. Head to toe assessment. The hospice provider was notified. The family member was notified. The MD was notified. The resident had a hematoma to face the size of an egg. Predisposing Physiological Factors-confused and impaired memory. Witnesses: No witnesses found. Review of Nursing Progress Note dated 04/07/2024 6:46 PM, written by the DON, for Resident #2 revealed, LATE ENTRY: This nurse was on phone video after permission obtained. This nurse noted bruise from top of hematoma down the right side of face to chin. It appears that the bruise had dissipated. Resident was in bed at time of assessment. Able to lift head. Charge nurse stated that the resident was up in chair for meals, and she was at baseline. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 04/07/2024 7:07 PM, written by LVN F for Resident #2 revealed, called hospice regarding hematoma to her forehead. Review of the Physician's Order dated 04/08/2024, provided by the DON for Resident #2 revealed, send resident to hospital via ambulance for a CT scan of the head. Review of the Nursing Progress Note dated 04/08/2024 11:30 AM, written by LVN G, for Resident #2 revealed, resident was picked up via ambulance to be transported to hospital to get CT scan of head and facial x-rays due to hematoma and scattered bruising to her face. The family and DON were contacted about transport. Review of CT Head Final Report dated 04/08/2024 1:23 PM, provided by the DON for Resident #2 revealed, Reason for Exam: Female, 99-years-old. Trauma. Findings: A right forehead scalp 1.5 x 2 cm diameter by 0. 9 cm thickness hematoma is seen. There is no intracranial hemorrhage. Impression: Right forehead scalp hematoma. Review of Resident #2's Medical Visit dated 04/15/2024 at 12:09 PM revealed the resident was found to have a large bruise to her forehead and bilateral (both) eye orbits. Per nursing reports the patient hit herself with the closing door. The patient continues under the care of hospice for terminal COPD. Past Medical History: Alzheimer Dementia, hypertension, HLD, Atrial Fibrillation, Hypothyroidism, Generalize anxiety, Major depressive disorder. Review of the Medication Administration Record dated April 04/01/24 - 04/30/2024, for Resident #2 revealed, Aspirin 81 mg give one tablet by mouth one time daily for PPX (Prophylaxis). Lorazepam Oral Concentrate 1 mg/0.5 ml give 1 mg by mouth evert 4 hours as needed for mild anxiety. Lorazepam Oral Concentrate 1 mg/0.5 ml give 2 mg by mouth evert 4 hours as needed for severe anxiety. In an interview on 04/23/24 at 3:24 PM, the DON stated, she did not recall if Resident #2 had been sent to the emergency room for a CT scan of the head. The DON stated, Let me check. An observation on 04/23/24 at 4:37 PM, revealed Resident #2 was sitting in a wheelchair in the hallway by the entrance to her room. The resident was oriented to her name and did not respond to simple questions. It was observed that Resident #2 had a fading, very light purple bruising to bilateral eyes, cheeks, and her nose. In a telephone interview on 04/24/24 at 10:34 AM, with Resident #2's family member revealed the staff reported they had found Resident #2 with a bump to her head. The origin of injury was unknown. The staff initially reported that Resident #2 had hit her head on the bed and then they kept changing the story. LVN F did not report the bump on the head to the DON and nothing was done about it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 11:22 AM, with the family member for Resident #2 revealed staff had reported to her that Resident #2 was pulling things from drawers/closets and maybe she had hit herself with the drawers or closet doors. On Friday 04/05/24 at breakfast, Resident #2 was throwing food, staff took her to her room and put her in bed. The staff reported that during rounds, they had noted the bruise to her face on 04/05/24. On Saturday 04/06/24 the family member reported she went to visit Resident #2 and noted purple bruises around her eyes. On Sunday 04/07/24 the family member reported she went to visit Resident #2 and found her sitting in her wheelchair, and her face was all purple. The family member reported she took the resident to the head nurse to see what they had done to address the bruising to her face. Resident #2 was sent on Monday 04/08/24 to hospital ambulance for a CT scan of the face. In an observation and interview on 04/24/24 at 11:33 PM, with LVN F on the day shift, revealed Resident #2 was in her room sitting in a wheelchair. The resident did not answer simple questions. It was observed the resident had fading, light purple bruising around the eye orbits down to her cheeks. LVN F stated, I was working on 04/05/24, when Resident #2 was found with the bump on her forehead the size of a quarter. The bump to her head was noted at approximately 1:30 PM on that day by the therapist. No other injuries were noted at the time of the assessment. LVN F reported that he and CNA H had seen Resident #2 forcefully opening & closing the closet doors and dresser drawers in her room and going through the dresser drawers. LVN F reported that on that day Resident #2 was agitated and was cursing. LVN F stated, I was working in the decentralized nurses' station that is close to Resident #2's room, and I heard loud banging of drawers, closet doors, and loud yelling. I went to the room to check and see if the Resident # 2 was OK. The door to the room was opened. It was already the end of the shift, and I was making the last round. CNA H was in the room attempting to calm down Resident #2. LVN F, stated, I assumed that Resident #2 got hit with the closet door on the face. The resident was not able to tell me what had happened. The resident was sitting in her wheelchair, was calm, and smiling at me. I assessed the resident and did not see any injuries at time of assessment. In an observation and interview on 04/24/24 at 12:03 PM, with CNA H, revealed that she worked on 04/05/24 on the morning shift and after breakfast heard someone yelling loudly and making a lot of noise. CNA stated, I walked down the hall and noticed the noise was coming from Resident #2's room. When I entered Resident #2's room she was by the window forcefully opening and forcefully closing the closet doors. The resident was also forcefully opening and closing the dresser drawers. The dresser drawers would bounce back and would slightly open when closed. I did not see resident get hit by the dresser drawers or the closet doors on that day. CNA H reported that she had left the room to allow [Resident #1] to calm down and went to report LVN F. CNA stated, In the evening, I was at the decentralized nurse's station feeding a resident when I saw one of the therapist's came to report to LVN F that Resident #2 had a bruise on forehead. I went to check the resident before the end of the shift and noted that she had a bruise on the forehead and down to the bridge of the nose. The next day when I returned to work on 04/06/24 on the day shift and noted Resident #2 had dark purple bruising on both eyes and on her cheeks. I remember that on that day, the hospice nurse came to see the resident. CNA H reported Resident #2 would take the clothes from the drawers and mix her clothes in her room mate's drawers and frequently refused care. CNA H stated they had been trained to report any behaviors immediately to the nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 5:59 PM with the COTA, revealed [Resident #2] was on hospice and was receiving occupational therapy. The COTA stated, I remember that on that day 04/05/24, I had not finished my therapy session and went later that afternoon to complete the therapy session. I wrote in my therapy notes that upon entering the room, I had noted [Resident #2] had a bruise on the forehead and immediately went to report this to LVN F on the morning shift. LVN F came to the room assessed the resident and said, it was a vein and not a bruise. The COTA agreed to email the surveyor a copy of the notes for 04/05/24. The therapy note was not emailed to the surveyor prior to exit on 04/24/24. In an interview and record review on 04/23/24 at 3:36 PM, with the Administer revealed a Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. Incidents that a NF Must Report to HHSC and the Time Frames for Reporting. A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Suspicious injuries of unknown source. Injuries of unknown source: Note: an injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. The Administrator stated, I did not think that the incidents involving Resident #1 and Resident #2 were reportable. However, after reading the provider letter, we should have reported these two incidents to state office and investigated the cause of injury. Review of facility's undated policy & procedure on Abuse, Neglect, and Exploitation provided by Administrator on 04/18/24 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitaion and misappropriation of resident property. Policy Explanation and Compliance Guidelines: The facility will develop and implement written policies and procedure that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations; The facility will designate an Abuse Prohibition Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Investigation of Alleged Abuse, Neglect and Exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Providing complete and through documentation of the investigation. Reporting/Response: The facility will have written policies the include: Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes.

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NAME OF PROVIDER OR SUPPLIER Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7441 Paseo Del Norte El Paso, TX 79911	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 of 4 (Resident #1 and Resident #2) reviewed for abuse and injuries of unknown origin. The facility failed to ensure Resident #1's and Resident #2's injuries of unknow origin were thoroughly investigated. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings include: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. Review of Resident #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. 04/18/24 Levaquin 500 mg give 1 tablet by mouth at bedtime for UTI for 7 days. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 11, Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 1. Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's SBAR Communication Form dated 04/17/24 at 10:40 AM, written by the DON for Resident #1 revealed, Situation: This started on: 04/17/24. Bruise found on top of forehead. This condition, symptoms, or sign has occurred before: No. Resident is on another anticoagulant. Vital signs B/P: 112/53, Pulse: 69, RR: 16, Temp: 98.4 Fahrenheit Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation (compared to baseline; check all that you observed) Needs more assistance with ADL's. Swallowing difficulty, weakness (general). Pain Evaluation: Yes. Neurological Evaluation: Resident in hallway and nurse noticed bruise/hematoma to right top of forehead. Review and Notify: Appearance: Resident in hallway and noticed bruise/hematoma to right top of forehead. Primary Care Clinician Notified: Yes. Date: 04/17/24. Time: 10:30 AM. Recommendations: Send to ER for evaluation and treatment. Review of Resident #1's Progress Note dated 04/17/24 for Resident #1 written by the FNP revealed, patient found sitting in the hallway with other residents, is less interactive today and appears drowsy and somnolent, oriented only to person Patient presents with right forehead swelling and ecchymosis (a small bruise caused by blood vessels into the tissues of the skin or mucous membranes) that was found by morning nurse. It is unknown if the patient fell and hit her head, but swelling is significant, and patient is altered from her baseline mental status. No other swelling, redness, ecchymosis during head-to-toe assessment. Plan to send the patient to the emergency department emergently for stat head CT. Patient cognitively impaired. Diagnosis: Traumatic hematoma of head. Agitation. Review of Resident #1's Physician's Order dated 04/17/24 at 10:59 AM, written by the FNP revealed, may send to ED for further evaluation of hematoma to the right upper forehead and altered mental status. Review of Resident #1's Emergency Department Encounter dated 04/17/24 at 12:13 PM revealed, Stated Complaint: Contusion .EMS. Chief Complaint: Head Pain/Injury. Patient's description of reason for visit: Pt. arrived via EMS after being called by Nursing Home for contusion found to right side of head. As reported to EMS, nursing home did not notice any symptoms related to trauma apart from contusion to head. Unwitnessed fall could have happened between 7:00 PM last night to 7:00 AM today. Objective assessment: Pt AAOx1 (name only). Chief Complaint: Head Pain. Pain intensity: 3. CT Brain w/o Contrast: 04/17/24 [AGE] years female, contusion. EMS; Head Contusion. Impression: Right frontal soft tissue hematoma without acute hemorrhage or extra-axial fluid collection (collection of blood or cerebrospinal fluid outside the brain and inner skull. CT Cervical Spine w/o contrast 04/17/24 Indication: [AGE] years female, contusion . EMS; Head Contusion. Impression: No acute abnormality of the cervical spine. Diagnosis: Head Contusion, UTI, and Pneumonia. Medications: Levaquin 500 mg orally daily for UTI/Pneumonia x 7 days 04/17/24 at 4:46 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's incident report dated 04/17/24 10:12 AM, for Resident #1 written by the DON revealed, resident was sitting in the hallway in her wheelchair and the nurse noted a bruise/hematoma to the right temple. There was a pinpoint red area in the middle of the hematoma. Asked resident if she fell , stated no but resident is Alert &Oriented to person and place. Record review of TULIP (computer software that tracks incident/complaint intakes reported to state office) revealed no self-report for Resident #1's injury of unknown origin to the right side of her forehead. Observation on 04/18/24 at 9:19 PM, revealed Resident #1 was lying in bed, asleep. The resident's low bed was against the wall, with a floor mat, and air mattress in place. The air mattress pump was hung on the foot board. The resident had an oxygen cannula in place and was receiving 2 L/Min of oxygen. The resident had a hematoma on right side of forehead with fading light purple discoloration from the hair line down to the mid-forehead measuring approximately 3 cm x 3 cm. Interview on 04/18/24 at 9:20 PM, with LVN A revealed he had worked on 04/17/24 on the 6 AM-2 PM shift, and that the night nurse did not mention during report at the change of shift that Resident #1 had a change in condition. LVN A stated, Later during the shift, when I went to check [Resident #1's] blood pressure, is when I noticed that she had a hematoma on the right side of forehead. I immediately reported this to the DON, who was at the facility at that time. [Resident #1] was sent to the emergency room by EMS on 04/17/24 for evaluation and returned with a diagnosis of UTI, pneumonia, hematoma to right side of forehead. Interview on 04/18/24 at 10:27 PM, with LVN B revealed she had worked on the night shift on 04/16/24 and was assigned to Resident #1. LVN B reported Resident #1 had not sustained a fall on her shift on that day. LVN B stated, On that day while I was making rounds at approximately 12 midnight, and I heard [Resident #1] making a lot of noise and was swearing. I went to the room and found Resident #1 lying in bed with her head on the foot of the bed. The right side of her face was against one of the metal hooks that hold the air mattress pump in place at the foot of the bed. Resident is confused, has incoherent speech and was not able to say what had happened. I called for help and [CNA C] came to the room to help me reposition the resident in bed. LVN B reported [Resident #1] was not able to stand without assistance. I administered Hydroxyzine to Resident #1 as ordered for anxiety that night because she was very restless and kept moving in bed. After the medication was administered, she slept the rest of the night on that day. I did not ask Resident #1 if she had sustained a fall on that day. I did not assess [Resident #1] on that day during the night shift since the resident had no apparent injury when she was repositioned in bed. LVN B reported she had not documented anything in the resident's clinical record on that day, since the resident did not have any apparent injuries when resident was moved from the foot of the bed to the head of the bed. I called the evening nurse and DON the next day on 04/17/24 to ask them if Resident #1 had sustained a fall in the morning or evening shift on 04/16/24 and both stated that the CNAs had not reported any falls on that day. At that time, the DON told me that Resident #1 was found in the morning on 04/17/24 with a hematoma to the right side of forehead. LVN B reported Resident #1 was very restless and moved constantly in bed and attempted to get out of bed without assistance. LVN B stated Resident #1 needed close supervision and re-direction to prevent falls. The nurse was not aware if the resident had a history of falls. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 10:46 PM, CNA C revealed Resident #1 was confused, and only oriented to person. CNA C reported Resident #1 became combative and pushed staff away when attempts were made to provide care, and very restless while in bed and moved around in her bed. CNA C reported Resident #1 had not sustained any falls during the night shift on 04/16/24. CNA C reported the DON had sent him a text message on 04/17/24 asking him if Resident #1 had sustained a fall on the night shift on 04/16/24. CNA C stated, On 04/16/24 at approximately 10:30 - 11:00 PM, [LVN B] called me to the room to assist her to reposition [Resident #1] in bed. Upon entering the room, I noted Resident #1 had slid down in the bed and was in a fetal position. We pulled her up in bed using the draw sheet and did not see any visible injuries at that time. CNA C denied finding the resident at the foot of the bed with her face on the air mattress pump on that day as reported by LVN B. Interview on 04/18/24 at 10:57 PM, with the Administrator revealed the night nurse had reported to LVN A that she had found [Resident #1] with her head on the air mattress pump at the foot of the bed and had no visible injuries at that time. On 04/17/24 LVN A noted Resident #1 had a bump on the right side of her forehead and was sent to the hospital for a CT scan. Resident #1 was confused and was not able to say how she got the bump on the right side of her forehead. The Administrator reported that the incident had not been reported to state office, because they went by what was reported by LVN B. In an interview on 04/23/24 at 10:22 AM, with CNA D revealed she was assigned to Resident #1 on 04/17/24 on the morning shift. CNA D stated, I do not remember what time I got [Resident #1] out of bed on that day and sat her in her wheelchair to take her to the dining room for breakfast. I did not notice any injuries when I combed her hair. After breakfast, I heard that [LVN A] and the Med Aide had noted the bruise to the right side of forehead and was sent to the hospital for evaluation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 04/23/24 at 3:46 PM, with the DON revealed Resident #1 was sitting in her wheelchair in the hallway, when she arrived at the facility on 04/17/24 at approximately 7:30 AM on that day. The DON reported LVN A had noted the bruise on Resident #1's forehead on 04/17/24 at approximately 8:30 AM - 9:00 AM, when he was going to check the resident's blood pressure. The DON stated the FNP was in the facility making rounds at that time and was notified of the contusion to the right side of Resident #1's forehead and gave orders to send the resident by ambulance to the hospital for a CT scan of her head. The DON reported LVN B who worked on the night shift had reported she had found Resident #1 upside down, with her head on the foot of the bed. LVN B reported that the resident's head was on the metal hook that was used to hang the pressure mattress air pump from the foot of the bed. The night nurse reported the resident did not have any visible injuries at that time. The Administrator decides when to report incidents to state office. The DON, stated, We did not consider this to be an injury of unknown origin because of how she was found at night in her bed with her head against the metal hook where the air mattress pump was attached. I guess that is how we weighed the situation. We did not investigate the injury, because we went by what the night nurse had reported to LVN A. DON, confirmed Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. DON stated that according to the Provider Letter the incidents for Resident #1 and Resident #2 should have been classified as injuries of unknown origin and should have been reported to state office since the residents were not able to explain how they got injured and there were no witnesses to the incidents. The DON stated, The Administrator I did not think that the incidents involving [Resident #1] and [Resident #2] were reportable based on what was reported by the nurses assigned to the residents. However, after reading the provider letter, we should have reported this incident to state office. In a telephone interview on 04/24/24 at 9:55 AM, the FNP revealed Resident #1 had been sent to the emergency department on 04/17/24 for evaluation of hematoma to the right side of her forehead and altered mental status. Resident #1 returned to the facility with a diagnosis of altered mental status, UTI, and pneumonia. Resident #1 was started on antibiotics and was getting oxygen. The FNP reported Resident #1 had a history of falls. The FNP stated the licensed staff should have reported to him on 04/16/24, that Resident #1 had been restless and moving in bed on the night shift and the Hydroxyzine was administered for anxiety. The FNP reported that he had arrived at the facility on 04/17/24 to make his routine rounds when LVN A had reported to him that he had noted Resident #1 had a contusion to the right side of her forehead and staff did not know how the resident had sustained the injury. The FNP stated that upon assessment on 04/17/24 Resident #1 was not at her baseline and he gave orders to send the resident to the emergency department for evaluation of altered mental status and contusion to the right side of her forehead. In a telephone interview on 04/23/24 at 10:39 AM, with LVN E revealed she had worked on the evening shift on 04/16/24 and Resident #1 had not had any falls or injuries during her shift. LVN E stated, I received a text message from [LVN B] that works on the night shift on 04/17/24 at 7:20 PM, asking if [Resident #1] had sustained a fall yesterday, because the day nurse had asked her if she had seen the bump on the resident's head. LVN B said that she had noticed anything on the night shift on 04/16/24 when she had given her the Hydroxyzine for anxiety. Resident #2 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Admission Record dated 04/23/24 at 3:06 PM, revealed admitted : 09/12/2020. admitted from hospital. Review of Medical Visit dated 04/15/2024 at 12:09 PM, History: Resident #2 revealed, [AGE] year-old female seen today for a Hospice follow-up visit. History of Present Illness: During this visit the patient was found to have a large bruise to her forehead and bilateral (both) eye orbits, per nursing reports the patient hit herself with the closing door. The patient continues under the care of Hospice of El Paso for terminal Chronic Obstructive Pulmonary Disease. Past Medical History: Alzheimer Dementia, Generalize anxiety, Major depressive disorder. Review of the MDS Quarterly Assessment, dated 01/26/2024 for Resident #2 revealed, hearing adequate; Clear speech; Rarely makes self-Understood; Rarely understands others; Vision Adequate; BIMS-score 0 (severely impaired); Acute onset Mental Status Change-Inattention, Disorganized Thinking; Behaviors: Physical Aggression-Behaviors of this type occurred 1 to 3 days. Verbal Aggression-Behaviors of this type occurred 1 to 3 days. Other behavioral symptoms not directed toward others-Behaviors of this type occurred 1 to 3 days. Rejection of Care Behaviors of this type occurred 1 to 3 days. Functional Limitation in Range of Motion: Impairment on one side - upper extremity. Impairment on both sides - lower extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, Oral hygiene dependent, toileting dependent, shower dependent, upper body dressing dependent, personal hygiene-dependent; lower body dressing substantial assistance. Mobility: Roll left and right-dependent; Sit to lying-dependent; Lying to sitting on side of bed-dependent; Sit to stand-dependent; Chair/bed transfer-dependent; Toilet transfer-dependent; shower-dependent; incontinent of bowel & bladder; Medications-Antidepressant, Antiplatelet; Hospice Care; Occupational Therapy. Review of the Care Plan revised 12/14/2021, for Resident #2 revealed, Cognitive Impairment r/t Alzheimer Dementia, impaired ability to make decisions, difficulty in expressing needs, impaired safety awareness. Potential for Injury r/t Actual falls, noncompliance with safety interventions, cognitive impairment, impaired safety-revised 06/12/2022. Require assistance with ADLs r/t cognitive deficits revised 08/01/2023. Potential for alteration in bleeding tendencies and increase bruising r/t use of anticoagulant/antiplatelet Aspirin revised 12/15/2021. Resident receiving Hospice Services r/t terminal disease COPD revised 07/21/2022. Episodes of adverse behaviors: Verbally aggressive-cursing, racial slurs, yelling/screaming; physically aggressive hitting staff or residents. Review of an Incident Report dated 04/05/2024 2:00 PM, written by LVN F for Resident #2 revealed, Resident #2 was agitated and aggressive this morning. After lunch time the resident presented with a hematoma to her forehead. The resident was in her room going through her personal belongings and the roommate's drawers and closets. The resident was transferred to bed and the CNA reported the resident's status. Head to toe assessment. The hospice provider was notified. The family member was notified. The MD was notified. The resident had a hematoma to face the size of an egg. Predisposing Physiological Factors-confused and impaired memory. Witnesses: No witnesses found. Review of Nursing Progress Note dated 04/07/2024 6:46 PM, written by the DON, for Resident #2 revealed, LATE ENTRY: This nurse was on phone video after permission obtained. This nurse noted bruise from top of hematoma down the right side of face to chin. It appears that the bruise had dissipated. Resident was in bed at time of assessment. Able to lift head. Charge nurse stated that the resident was up in chair for meals, and she was at baseline. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7441 Paseo Del Norte El Paso, TX 79911	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note dated 04/07/2024 7:07 PM, written by LVN F for Resident #2 revealed, called hospice regarding hematoma to her forehead. Review of the Physician's Order dated 04/08/2024, provided by the DON for Resident #2 revealed, send resident to hospital via ambulance for a CT scan of the head. Review of the Nursing Progress Note dated 04/08/2024 11:30 AM, written by LVN G, for Resident #2 revealed, resident was picked up via ambulance to be transported to hospital to get CT scan of head and facial x-rays due to hematoma and scattered bruising to her face. The family and DON were contacted about transport. Review of CT Head Final Report dated 04/08/2024 1:23 PM, provided by the DON for Resident #2 revealed, Reason for Exam: Female, 99-years-old. Trauma. Findings: A right forehead scalp 1.5 x 2 cm diameter by 0. 9 cm thickness hematoma is seen. There is no intracranial hemorrhage. Impression: Right forehead scalp hematoma. Review of Resident #2's Medical Visit dated 04/15/2024 at 12:09 PM revealed the resident was found to have a large bruise to her forehead and bilateral (both) eye orbits. Per nursing reports the patient hit herself with the closing door. The patient continues under the care of hospice for terminal COPD. Past Medical History: Alzheimer Dementia, hypertension, HLD, Atrial Fibrillation, Hypothyroidism, Generalize anxiety, Major depressive disorder. Review of the Medication Administration Record dated April 04/01/24 - 04/30/2024, for Resident #2 revealed, Aspirin 81 mg give one tablet by mouth one time daily for PPX (Prophylaxis). Lorazepam Oral Concentrate 1 mg/0.5 ml give 1 mg by mouth evert 4 hours as needed for mild anxiety. Lorazepam Oral Concentrate 1 mg/0.5 ml give 2 mg by mouth evert 4 hours as needed for severe anxiety. In an interview on 04/23/24 at 3:24 PM, the DON stated, she did not recall if Resident #2 had been sent to the emergency room for a CT scan of the head. The DON stated, Let me check. An observation on 04/23/24 at 4:37 PM, revealed Resident #2 was sitting in a wheelchair in the hallway by the entrance to her room. The resident was oriented to her name and did not respond to simple questions. It was observed that Resident #2 had a fading, very light purple bruising to bilateral eyes, cheeks, and her nose. In a telephone interview on 04/24/24 at 10:34 AM, with Resident #2's family member revealed the staff reported they had found Resident #2 with a bump to her head. The origin of injury was unknown. The staff initially reported that Resident #2 had hit her head on the bed and then they kept changing the story. LVN F did not report the bump on the head to the DON and nothing was done about it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 11:22 AM, with the family member for Resident #2 revealed staff had reported to her that Resident #2 was pulling things from drawers/closets and maybe she had hit herself with the drawers or closet doors. On Friday 04/05/24 at breakfast, Resident #2 was throwing food, staff took her to her room and put her in bed. The staff reported that during rounds, they had noted the bruise to her face on 04/05/24. On Saturday 04/06/24 the family member reported she went to visit Resident #2 and noted purple bruises around her eyes. On Sunday 04/07/24 the family member reported she went to visit Resident #2 and found her sitting in her wheelchair, and her face was all purple. The family member reported she took the resident to the head nurse to see what they had done to address the bruising to her face. Resident #2 was sent on Monday 04/08/24 to hospital ambulance for a CT scan of the face. In an observation and interview on 04/24/24 at 11:33 PM, with LVN F on the day shift, revealed Resident #2 was in her room sitting in a wheelchair. The resident did not answer simple questions. It was observed the resident had fading, light purple bruising around the eye orbits down to her cheeks. LVN F stated, I was working on 04/05/24, when Resident #2 was found with the bump on her forehead the size of a quarter. The bump to her head was noted at approximately 1:30 PM on that day by the therapist. No other injuries were noted at the time of the assessment. LVN F reported that he and CNA H had seen Resident #2 forcefully opening & closing the closet doors and dresser drawers in her room and going through the dresser drawers. LVN F reported that on that day Resident #2 was agitated and was cursing. LVN F stated, I was working in the decentralized nurses' station that is close to Resident #2's room, and I heard loud banging of drawers, closet doors, and loud yelling. I went to the room to check and see if the Resident # 2 was OK. The door to the room was opened. It was already the end of the shift, and I was making the last round. CNA H was in the room attempting to calm down Resident #2. LVN F, stated, I assumed that Resident #2 got hit with the closet door on the face. The resident was not able to tell me what had happened. The resident was sitting in her wheelchair, was calm, and smiling at me. I assessed the resident and did not see any injuries at time of assessment. In an observation and interview on 04/24/24 at 12:03 PM, with CNA H, revealed that she worked on 04/05/24 on the morning shift and after breakfast heard someone yelling loudly and making a lot of noise. CNA stated, I walked down the hall and noticed the noise was coming from Resident #2's room. When I entered Resident #2's room she was by the window forcefully opening and forcefully closing the closet doors. The resident was also forcefully opening and closing the dresser drawers. The dresser drawers would bounce back and would slightly open when closed. I did not see resident get hit by the dresser drawers or the closet doors on that day. CNA H reported that she had left the room to allow [Resident #1] to calm down and went to report LVN F. CNA stated, In the evening, I was at the decentralized nurse's station feeding a resident when I saw one of the therapist's came to report to LVN F that Resident #2 had a bruise on forehead. I went to check the resident before the end of the shift and noted that she had a bruise on the forehead and down to the bridge of the nose. The next day when I returned to work on 04/06/24 on the day shift and noted Resident #2 had dark purple bruising on both eyes and on her cheeks. I remember that on that day, the hospice nurse came to see the resident. CNA H reported Resident #2 would take the clothes from the drawers and mix her clothes in her room mate's drawers and frequently refused care. CNA H stated they had been trained to report any behaviors immediately to the nurses. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/24/24 at 5:59 PM with the COTA, revealed [Resident #2] was on hospice and was receiving occupational therapy. The COTA stated, I remember that on that day 04/05/24, I had not finished my therapy session and went later that afternoon to complete the therapy session. I wrote in my therapy notes that upon entering the room, I had noted [Resident #2] had a bruise on the forehead and immediately went to report this to LVN F on the morning shift. LVN F came to the room assessed the resident and said, it was a vein and not a bruise. The COTA agreed to email the surveyor a copy of the notes for 04/05/24. The therapy note was not emailed to the surveyor prior to exit on 04/24/24. In an interview and record review on 04/23/24 at 3:36 PM, with the Administer revealed a Provider Letter dated July 10, 2019, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and other Incidents that a Nursing (NF) Must Report to the Health and Human Services Commission (HHSC). 2.0 Policy Details & Provider Responsibilities. Incidents that a NF Must Report to HHSC and the Time Frames for Reporting. A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Suspicious injuries of unknown source. Injuries of unknown source: Note: an injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. The Administrator stated, I did not think that the incidents involving Resident #1 and Resident #2 were reportable. However, after reading the provider letter, we should have reported these two incidents to state office and investigated the cause of injury. Review of facility's undated policy & procedure on Abuse, Neglect, and Exploitation provided by Administrator on 04/18/24 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitaion and misappropriation of resident property. Policy Explanation and Compliance Guidelines: The facility will develop and implement written policies and procedure that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations; The facility will designate an Abuse Prohibition Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Investigation of Alleged Abuse, Neglect and Exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Providing complete and through documentation of the investigation. Reporting/Response: The facility will have written policies the include: Reporting of all alleged violations to the Administrator, state agency, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observations, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Residents #1, and Resident #4) of 4 residents reviewed for accuracy of MDS assessments. - The facility failed to ensure that Resident #1's MDS accurately reflected resident's behaviors that put her at risk for falls. -The facility failed to ensure that Resident's #3's MDS accurately reflected resident had a history fo falls and use of anti-anxiety medication. These failures could put residents at risk of not receiving the necessary care and services to prevent falls and injuries related to inaccurate MDS assessment. Findings included: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. Interview and record review on 04/24/24 at 10:00 AM, with DON revealed, Resident #1's Admission Minimum Data Set (MDS) dated [DATE], did not document resident's behaviors that put her at risk of falls. DON stated, We are aware that behaviors were not documented on the MDS Assessments by the former MDS nurse. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 Review of the Admission Record dated 04/23/24 at 5:02 PM for Resident #4, revealed, Original admitted : 01/18/2024. Review of History & Physical dated 01/22/2024, Resident #4 revealed, [AGE] year-old male Past Medical History: Diabetes Mellitus, hypertension, coronary artery disease, benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine), paroxysmal atrial fibrillation (when heartbeat returns to normal within 7 days on its own or with treatment), iron deficiency anemia and Dementia associated with alcoholism with behavioral disturbance. Review of the PPS 5-day Scheduled MDS dated [DATE], for Resident #4 revealed, hearing adequate; clear speech; makes self-understood; understands others; vision adequate; BIMS-score 2 (severely impaired); Functional Limitation in Range of Motion: Impairment on both sides - upper extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, oral hygiene supervision, toileting substantial assistance, shower substantial assistance, upper body dressing substantial assistance, lower body dressing substantial assistance. Mobility: Roll left and right-substantial assistance; Sit to lying- substantial assistance; Lying to sitting on side of bed- substantial assistance; Sit to stand- substantial assistance; Chair/bed transfer-substantial assistance; Toilet transfer- substantial assistance; Indwelling catheter. incontinent of bowel; Falls since admission with no injury. Medications-antipsychotic; Speech/Occupational/Physical therapy. Interview and record review on 04/24/24 at 6:55 PM, with DON, revealed PPS 5-day Scheduled MDS dated [DATE], for Resident #4 anti-anxiety medication use and history of falls prior to admission to the nursing facility. Review of facility's policy on undated policy & procedure on Conducting an Accurate Assessment provided by DON on 04/23/24 revealed, Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Policy explanation: Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the clinical record. The appropriate, qualified health professional will correctly document the resident's medical status, functional abilities, and psychosocial status.

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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** 20026 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 3 of 4 residents (Resident #1, Resident #2, and Resident #4) reviewed for comprehensive care plans in that: - The facility failed to develop a comprehensive care plan for Resident #1 that addressed antiplatelet platelet medication, feeding tube, restlessness when in bed, anti-anxiety medication, hematoma to right side of head, UTI, and pneumonia. - The facility failed to develop a comprehensive care plan for Resident #2 that addressed restlessness while in bed and orders for anti-anxiety, hematoma to the right side of forehead, behaviors and risk for bruising r/t use of ASA 81 mg. -The facility failed to develop a comprehensive care plan for Resident #4 that addressed restlessness while in bed, anti-anxiety/anti-psychotic medication use, pneumonia, a UTI treated with antibiotics, hematoma to the right side of forehead and risk for bruising r/t use of ASA 81 mg, suprapubic catheter and incontinence of bowel, receiving rehabilitation services, skin tear to left lower extremity, use of abdominal binder. Refused care and medications. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and not having personalized plans developed to address their needs. Findings include: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Feeding Tube; Seizure Disorder; Speech/Physical therapy. (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 #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. 04/18/24 Levaquin 500 mg give 1 tablet by mouth at bedtime for UTI for 7 days. The physician's orders did not document an order for Entral Feedings or Mechanically altered diet. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke did not reflect the level of assistance provided by staff. Hypertension at risk for blurred vision, vertigo, headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. The care plan did not address restlessness while in bed; use of anti-anxiety medication revised on 04/23/24; pneumonia; UTI treated with antibiotics; hematoma to the right side of forehead; restlessness when in bed; 04/17/24 Urinary Tract Infection/Pneumonia; and mechanically altered diet, were not care planned. Resident #2 Review of Resident #2's Admission Record dated 04/23/24 at 3:06 PM, revealed admitted : 09/12/2020. admitted from hospital. Review of Medical Visit dated 04/15/2024 at 12:09 PM, History: Resident #2 revealed, [AGE] year-old female seen today for a Hospice follow-up visit. History of Present Illness: During this visit the patient was found to have a large bruise to her forehead and bilateral (both) eye orbits, per nursing reports the patient hit herself with the closing door. The patient continues under the care of Hospice of El Paso for terminal Chronic Obstructive Pulmonary Disease. Past Medical History: Alzheimer Dementia, Generalize anxiety, Major depressive disorder. Review of the MDS Quarterly Assessment, dated 01/26/2024 for Resident #2 revealed, hearing adequate; Clear speech; Rarely makes self-Understood; Rarely understands others; Vision Adequate; BIMS-score 0 (severely impaired); Acute onset Mental Status Change-Inattention, Disorganized Thinking; Behaviors: Physical Aggression-Behaviors of this type occurred 1 to 3 days. Verbal Aggression-Behaviors of this type occurred 1 to 3 days. Other behavioral symptoms not directed toward others-Behaviors of this type occurred 1 to 3 days. Rejection of Care Behaviors of this type occurred 1 to 3 days. Functional Limitation in Range of Motion: Impairment on one side - upper extremity. Impairment on both sides - lower extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, Oral hygiene dependent, toileting dependent, shower dependent, upper body dressing dependent, personal hygiene-dependent; lower body dressing substantial assistance. Mobility: Roll left and right-dependent; Sit to lying-dependent; Lying to sitting on side of bed-dependent; Sit to stand-dependent; Chair/bed transfer-dependent; Toilet transfer-dependent; shower-dependent; incontinent of bowel & bladder; Medications-Antidepressant, Antiplatelet; Hospice Care; Occupational Therapy. (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 the Care Plan revised 12/14/2021, for Resident #2 revealed, Cognitive Impairment r/t Alzheimer Dementia, impaired ability to make decisions, difficulty in expressing needs, impaired safety awareness. Potential for Injury r/t Actual falls, noncompliance with safety interventions, cognitive impairment, impaired safety-revised 06/12/2022. Require assistance with ADLs r/t cognitive deficits revised 08/01/2023. Potential for alteration in bleeding tendencies and increase bruising r/t use of anticoagulant/antiplatelet Aspirin revised 12/15/2021. Resident receiving Hospice Services r/t terminal disease COPD revised 07/21/2022. Episodes of adverse behaviors: Verbally aggressive-cursing, racial slurs, yelling/screaming; physically aggressive hitting staff or residents.The care plan did not address use of anti-anxiety medication revised on 04/23/24; Hematoma to the righ side of forehead; restlessness while in bed; risk for bruising r/t use of ASA 81 mg; Urinary Tract Infection; Pneumonia and mechanically diet. Review of an Incident Report dated 04/05/2024 2:00 PM, written by LVN F for Resident #2 revealed, Resident #2 was agitated and aggressive this morning. After lunch time the resident presented with a hematoma to her forehead. The resident was in her room going through her personal belongings and the roommate's drawers and closets. The resident was transferred to bed and the CNA reported the resident's status. Head to toe assessment. The hospice provider was notified. The family member was notified. The MD was notified. The resident had a hematoma to face the size of an egg. Predisposing Physiological Factors-confused and impaired memory. Witnesses: No witnesses found. Review of the Nursing Progress Note dated 04/07/2024 7:07 PM, written by LVN F for Resident #2 revealed, called hospice regarding hematoma to her forehead. Review of the Physician's Order dated 04/08/2024, provided by the DON for Resident #2 revealed, send resident to hospital via ambulance for a CT scan of the head. Review of the Nursing Progress Note dated 04/08/2024 11:30 AM, written by LVN G, for Resident #2 revealed, resident was picked up via ambulance to be transported to hospital to get CT scan of head and facial x-rays due to hematoma and scattered bruising to her face. The family and DON were contacted about transport. Review of CT Head Final Report dated 04/08/2024 1:23 PM, provided by the DON for Resident #2 revealed, Reason for Exam: Female, 99-years-old. Trauma. Findings: A right forehead scalp 1.5 x 2 cm diameter by 0. 9 cm thickness hematoma is seen. There is no intracranial hemorrhage. Impression: Right forehead scalp hematoma. Resident #4 Review of the Admission Record dated 04/23/24 at 5:02 PM for Resident #4, revealed, Original admitted : 01/18/2024. Review of History & Physical dated 01/22/2024, Resident #4 revealed, [AGE] year-old male Past Medical History: Diabetes Mellitus, hypertension, coronary artery disease, benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine), paroxysmal atrial fibrillation (when heartbeat returns to normal within 7 days on its own or with treatment), iron deficiency anemia and Dementia associated with alcoholism with behavioral disturbance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PPS 5-day Scheduled MDS dated [DATE], for Resident #4 revealed, hearing adequate; clear speech; makes self-understood; understands others; vision adequate; BIMS-score 2 (severely impaired); Functional Limitation in Range of Motion: Impairment on both sides - upper extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, oral hygiene supervision, toileting substantial assistance, shower substantial assistance, upper body dressing substantial assistance, lower body dressing substantial assistance. Mobility: Roll left and right-substantial assistance; Sit to lying- substantial assistance; Lying to sitting on side of bed- substantial assistance; Sit to stand- substantial assistance; Chair/bed transfer- substantial assistance; Toilet transfer- substantial assistance; Indwelling catheter. incontinent of bowel; Falls since admission with no injury. Medications-antipsychotic; Speech/Occupational/Physical therapy. Review of the Care Plan, for Resident #4 revealed, revealed Stage II pressure ulcer to sacrum and DTI to right heel r/t history of ulcers and immobility revised 02/06/2024. Skin tear to left shin and right elbow r/t fragile skin revised 04/19/24. Care plan did not address ADL deficit; addressed restlessness while in bed, anti-anxiety medication use, pneumonia, a UTI treated with antibiotics, hematoma to the right side of forehead and risk for bruising r/t use of ASA 81 mg, suprapubic catheter and incontinence of bowel, receiving rehabilitation services, skin tear to left lower extremity, use of abdominal binder. Review of the Physician's Order Active Order Summary dated 04/23/2024 for Resident #4 revealed, Hydroxyzine HCL 25 mg give 2 tablets by mouth every 24 hours as needed for agitation/anxiety at HS-order date 03/04/24. Pallperidone ER 1.5 mg give 2 tablets by mouth at bedtime for mood disorder-order date 02/21/24. Suprapubic catheter. Cleanse skin tear to left lower extremity with normal saline, pat dry, and apply xerofoam, cover with dressing QOD & PRN. PT/OT/ST evaluate & treat as warranted. Abdominal Binder. Review of electronic nurse progress notes dated 02/02/24 through 04/22/24 for Resident #4 revealed, resident refusing to go to bed and attempted to stand up without assistance; refused medications and meals; ambulated without assistance. Skin tear to left lower shin; antibiotic for UTI; Found on floor lying on floor mat next to bed. The surveyor requested a copy of facility's policy on comprehensive care plans on 04/24/24 at 5:00 PM. The DON did not provide the surveyor a copy of the comprehensive care plans prior to exit.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interviews and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 3 (Resident #1, Resident #2, and Resident #4) of 4 residents reviewed for neurological checks. -The facility failed to ensure Resident #1 had neurological checks done after she was found with a hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space) to right side of forehead on 04/17/23 on the morning shift. -The facility failed to ensure Resident #2 had neurological checks done after she was found with a hematoma on the forehead on 04/05/23 on the morning shift. -The facility failed to ensure Resident #4 had had neurological checks done after he was found on the floor on 02/03/24 and could not say what had happened and if he had hit his head. This failure could affect residents by placing them at risk of changes in condition due to not conducting neurological checks. Findings included: Resident #1 Review of Resident #1's Admission Record dated 04/18/24 revealed Initial admitted : 01/23/2024. admitted : 02/11/2024. admitted from the hospital. Review of Resident #1's History & Physical dated 01/23/2024, revealed a [AGE] year-old with a history of diabetes mellitus type 2, hypertension, and atrial fibrillation (an irregular heartbeat) and anemia. The resident was cognitively impaired; alert and oriented x 0 (resident was not oriented to person, place, or time). Review of Resident #1's Admission Minimum Data Set (MDS) dated [DATE], revealed, : Hearing minimal difficulty; Unclear speech; understood; understands; Vision adequate; BIMS score: 0 (severely cognitively impaired); Functional limitation in Range of Motion to lower extremities; wheelchair; Functional Abilities on admission: eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, personal hygiene-dependent; Roll left & right-dependent; Sit to lying dependent; Lying to sitting on side of bed dependent; Sit to stand dependent; Chair/bed transfer dependent; Toilet transfer dependent; shower dependent; incontinent of bowel & bladder; Antiplatelet; Speech/Physical therapy. Review of Resident #1's Care Plan revised on 02/26/24, revealed, potential for impaired skin integrity r/t decreased mobility, incontinence, low albumin, and low protein intake. At risk for injury r/t seizure disorder. Potential for self-care deficit in ADL's r/t stroke. Hypertension at risk for blurred vision, vertigo (is a sensation of motion or spinning that is often described as dizziness), headache, and nosebleed. Episodes of anxiety and at risk for fluctuation in moods. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 11, Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of Resident #1's Fall Risk assessment dated [DATE] revealed, Score: 1. Category: High Risk. Intermittent Confusion. 1-2 Fall in the past 1-2 months. Chair Bound. Vision: Adequate; Gait/Balance: Requires use of assistive devices (w/c); Medications takes 1-2 of these medications currently and/or within last 7 days. Anti-hypertensives, Anti-seizure. Predisposing Diseases: None Present. Review of the Incident Log dated 04/18/24 provided by the DON revealed Resident #1 had a bruise on 04/17/24 to the forehead. Review of Resident #1's SBAR Communication Form dated 04/17/24 at 10:40 AM, written by the DON for Resident #1 revealed, Situation: This started on: 04/17/24. Bruise found on top of forehead. This condition, symptoms, or sign has occurred before: No. Resident is on another anticoagulant. Vital signs B/P: 112/53, Pulse: 69, RR: 16, Temp: 98.4 Fahrenheit Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation (compared to baseline; check all that you observed) Needs more assistance with ADL's. Swallowing difficulty, weakness (general). Pain Evaluation: Yes. Neurological Evaluation: Resident in hallway and nurse noticed bruise/hematoma to right top of forehead. Review and Notify: Appearance: Resident in hallway and noticed bruise/hematoma to right top of forehead. Primary Care Clinician Notified: Yes. Date: 04/17/24. Time: 10:30 AM. Recommendations: Send to ER for evaluation and treatment. Review of Resident #1's Progress Note dated 04/17/24 for Resident #1 written by the FNP revealed, patient found sitting in the hallway with other residents, is less interactive today and appears drowsy and somnolent, oriented only to person Patient presents with right forehead swelling and ecchymosis (a small bruise caused by blood vessels into the tissues of the skin or mucous membranes) that was found by morning nurse. It is unknown if the patient fell and hit her head, but swelling is significant, and patient is altered from her baseline mental status. No other swelling, redness, ecchymosis during head-to-toe assessment. Plan to send the patient to the emergency department emergently for stat head CT. Patient cognitively impaired. Diagnosis: Traumatic hematoma of head. Agitation. Review of Resident #1's Review of Physician Order Summary date April 18, 2024, at 10:16 PM revealed, Active Orders as of: 04/19/24 - 03/13/24 Antiplatelet monitoring-bleeding, pruritus (feeling or sensation on your skin that you want to scratch), abnormal bleeding and/or bruising every shift; 04/17/24 May send to ED (Emergency Department) for further evaluation of hematoma to the right upper forehead and altered mental status. 03/10/24 Aspirin 81 mg orally one time a day for PPX. 03/10/24 Hydroxyzine HCL 25 mg give 50 mg by mouth every 6 hours as needed for anxiety. Review of Resident #1's Physician's Order dated 04/17/24 at 10:59 AM, written by the FNP revealed, may send to ED for further evaluation of hematoma to the right upper forehead and altered mental status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Emergency Department Encounter dated 04/17/24 at 12:13 PM revealed, Stated Complaint: Contusion .EMS. Chief Complaint: Head Pain/Injury. Patient's description of reason for visit: Pt. arrived via EMS after being called by Nursing Home for contusion found to right side of head. As reported to EMS, nursing home did not notice any symptoms related to trauma apart from contusion to head. Unwitnessed fall could have happened between 7:00 PM last night to 7:00 AM today. Objective assessment: Pt AAOx1 (name only). Chief Complaint: Head Pain. Pain intensity: 3. CT Brain w/o Contrast: 04/17/24 [AGE] years female, contusion. EMS; Head Contusion. Impression: Right frontal soft tissue hematoma without acute hemorrhage or extra-axial fluid collection (collection of blood or cerebrospinal fluid outside the brain and inner skull. CT Cervical Spine w/o contrast 04/17/24 Indication: [AGE] years female, contusion . EMS; Head Contusion. Impression: No acute abnormality of the cervical spine. Diagnosis: Head Contusion, UTI, and Pneumonia. Medications: Levaquin 500 mg orally daily for UTI/Pneumonia x 7 days 04/17/24 at 4:46 PM. Review of Resident #1's incident report dated 04/17/24 10:12 AM, for Resident #1 written by the DON revealed, resident was sitting in the hallway in her wheelchair and the nurse noted a bruise/hematoma to the right temple. There was a pinpoint red area in the middle of the hematoma. Asked resident if she fell , stated no but resident is Alert &Oriented to person and place. Observation on 04/18/24 at 9:19 PM, revealed Resident #1 was lying in bed, asleep. The resident's low bed was against the wall, with a floor mat, and air mattress in place. The air mattress pump was hung on the foot board. The resident had an oxygen cannula in place and was receiving 2 L/Min of oxygen. The resident had a hematoma on right side of forehead with fading light purple discoloration from the hair line down to the mid-forehead measuring approximately 3 cm x 3 cm. Interview on 04/18/24 at 9:20 PM, with LVN A revealed he had worked on 04/17/24 on the 6 AM-2 PM shift, and that the night nurse did not mention during report at the change of shift that Resident #1 had a change in condition. LVN A stated, Later during the shift, when I went to check [Resident #1's] blood pressure, is when I noticed that she had a hematoma on the right side of forehead. I immediately reported this to the DON, who was at the facility at that time. [Resident #1] was sent to the emergency room by EMS on 04/17/24 for evaluation and returned with a diagnosis of UTI, pneumonia, hematoma to right side of forehead. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/18/24 at 10:27 PM, with LVN B revealed she had worked on the night shift on 04/16/24 and was assigned to Resident #1. LVN B reported Resident #1 had not sustained a fall on her shift on that day. LVN B stated, On that day while I was making rounds at approximately 12 midnight, and I heard [Resident #1] making a lot of noise and was swearing. I went to the room and found Resident #1 lying in bed with her head on the foot of the bed. The right side of her face was against one of the metal hooks that hold the air mattress pump in place at the foot of the bed. Resident is confused, has incoherent speech and was not able to say what had happened. I called for help and [CNA C] came to the room to help me reposition the resident in bed. LVN B reported [Resident #1] was not able to stand without assistance. I administered Hydroxyzine to Resident #1 as ordered for anxiety that night because she was very restless and kept moving in bed. After the medication was administered, she slept the rest of the night on that day. I did not ask Resident #1 if she had sustained a fall on that day. I did not assess [Resident #1] on that day during the night shift since the resident had no apparent injury when she was repositioned in bed. LVN B reported she had not documented anything in the resident's clinical record on that day, since the resident did not have any apparent injuries when resident was moved from the foot of the bed to the head of the bed. I called the evening nurse and DON the next day on 04/17/24 to ask them if Resident #1 had sustained a fall in the morning or evening shift on 04/16/24 and both stated that the CNAs had not reported any falls on that day. At that time, the DON told me that Resident #1 was found in the morning on 04/17/24 with a hematoma to the right side of forehead. LVN B reported Resident #1 was very restless and moved constantly in bed and attempted to get out of bed without assistance. LVN B stated Resident #1 needed close supervision and re-direction to prevent falls. The nurse was not aware if the resident had a history of falls. Interview on 04/18/24 at 10:46 PM, CNA C revealed Resident #1 was confused, and only oriented to person. CNA C reported Resident #1 became combative and pushed staff away when attempts were made to provide care, and very restless while in bed and moved around in her bed. CNA C reported Resident #1 had not sustained any falls during the night shift on 04/16/24. CNA C reported the DON had sent him a text message on 04/17/24 asking him if Resident #1 had sustained a fall on the night shift on 04/16/24. CNA C stated, On 04/16/24 at approximately 10:30 - 11:00 PM, [LVN B] called me to the room to assist her to reposition [Resident #1] in bed. Upon entering the room, I noted Resident #1 had slid down in the bed and was in a fetal position. We pulled her up in bed using the draw sheet and did not see any visible injuries at that time. CNA C denied finding the resident at the foot of the bed with her face on the air mattress pump on that day as reported by LVN B. Interview on 04/18/24 at 10:57 PM, with the Administrator revealed the night nurse had reported to LVN A that she had found [Resident #1] with her head on the air mattress pump at the foot of the bed and had no visible injuries at that time. On 04/17/24 LVN A noted Resident #1 had a bump on the right side of her forehead and was sent to the hospital for a CT scan. Resident #1 was confused and was not able to say how she got the bump on the right side of her forehead. In an interview on 04/23/24 at 10:22 AM, with CNA D revealed she was assigned to Resident #1 on 04/17/24 on the morning shift. CNA D stated, I do not remember what time I got [Resident #1] out of bed on that day and sat her in her wheelchair to take her to the dining room for breakfast. I did not notice any injuries when I combed her hair. After breakfast, I heard that [LVN A] and the Med Aide had noted the bruise to the right side of forehead and was sent to the hospital for evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 04/23/24 at 10:39 AM, with LVN E revealed she had worked on the evening shift on 04/16/24 and Resident #1 had not had any falls or injuries during her shift. LVN E stated, I received a text message from [LVN B] that works on the night shift on 04/17/24 at 7:20 PM, asking if [Resident #1] had sustained a fall yesterday, because the day nurse had asked her if she had seen the bump on the resident's head. LVN B said that she had noticed anything on the night shift on 04/16/24 when she had given her the Hydroxyzine for anxiety. Interview and record review on 04/23/24 at 3:46 PM, with the DON revealed Resident #1 was sitting in her wheelchair in the hallway, when she arrived at the facility on 04/17/24 at approximately 7:30 AM on that day. The DON reported LVN A had noted the bruise on Resident #1's forehead on 04/17/24 at approximately 8:30 AM - 9:00 AM, when he was going to check the resident's blood pressure. The DON stated the FNP was in the facility making rounds at that time and was notified of the contusion to the right side of Resident #1's forehead and gave orders to send the resident by ambulance to the hospital for a CT scan of her head. The DON reported LVN B who worked on the night shift had reported she had found Resident #1 upside down, with her head on the foot of the bed. LVN B reported that the resident's head was on the metal hook that was used to hang the pressure mattress air pump from the foot of the bed. The night nurse reported the resident did not have any visible injuries at that time. In a telephone interview on 04/24/24 at 9:55 AM, the FNP revealed Resident #1 had been sent to the emergency department on 04/17/24 for evaluation of hematoma to the right side of her forehead and altered mental status. Resident #1 returned to the facility with a diagnosis of altered mental status, UTI, and pneumonia. Resident #1 was started on antibiotics and was getting oxygen. The FNP reported Resident #1 had a history of falls. The FNP stated the licensed staff should have reported to him on 04/16/24, that Resident #1 had been restless and moving in bed on the night shift and the Hydroxyzine was administered for anxiety. The FNP reported that he had arrived at the facility on 04/17/24 to make his routine rounds when LVN A had reported to him that he had noted Resident #1 had a contusion to the right side of her forehead and staff did not know how the resident had sustained the injury. The FNP stated that upon assessment on 04/17/24 Resident #1 was not at her baseline and he gave orders to send the resident to the emergency department for evaluation of altered mental status and contusion to the right side of her forehead. In a second interview on 04/23/24 at 4:01 PM, with LVN A, revealed that on 04/17/24 at approximately 7:00 AM - 8:00 AM, he went to check resident's blood pressure and that is when he noted Resident #1 had a hematoma to the right side of her forehead, that was approximately the size of an egg and had started to turn a light purple. LVN A stated, The FNP was at the facility at the time, when I noticed the hematoma on Resident #1's forehead. The FNP examined [Resident #1] and gave orders to send the resident to the emergency room for evaluation by ambulance. I called EMS and sent [Resident #1]to the hospital as ordered. LVN A stated Resident #1 was confused and was not able say how she got the hematoma to the right side of the head. I did not initiate neuro checks since I did not know the time that the injury had occurred. LVN A stated the nurses had been trained to immediately initiate neuro checks for all unwitnessed falls and or suspected head injuries x 72 hours according to facility policy and procedure. The FNP did not tell me to start neuro checks on the day on Resident #1. I remember that I checked her vital signs and checked her pupils that were reactive to light. The resident was alert and was able to answer simple questions. There are a lot of residents in the 200 hall, and I got busy and forgot to document my assessment in the electronic progress notes. Resident #2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Admission Record dated 04/23/24 at 3:06 PM, revealed admitted : 09/12/2020. admitted from hospital. Review of Medical Visit dated 04/15/2024 at 12:09 PM, History: Resident #2 revealed, [AGE] year-old female seen today for a Hospice follow-up visit. History of Present Illness: During this visit the patient was found to have a large bruise to her forehead and bilateral eye orbits, per nursing reports the patient hit herself with the closing door. The patient continues under the care of Hospice of El Paso for terminal Chronic Obstructive Pulmonary Disease. Past Medical History: Alzheimer Dementia, hypertension, Atrial Fibrillation, Generalize anxiety, Major depressive disorder. Review of MDS Quarterly Assessment, dated 01/26/2024 for Resident #2 revealed, hearing adequate; Clear speech; Rarely makes self-Understood; Rarely understands others; Vision Adequate; BIMS-score 0 (severely impaired); Acute onset Mental Status Change-Inattention, Disorganized Thinking; Behaviors: Physical Aggression-Behaviors of this type occurred 1 to 3 days. Verbal Aggression-Behaviors of this type occurred 1 to 3 days. Other behavioral symptoms not directed toward others-Behaviors of this type occurred 1 to 3 days. Rejection of Care Behaviors of this type occurred 1 to 3 days. Functional Limitation in Range of Motion: Impairment on one side - upper extremity. Impairment on both sides - lower extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, Oral hygiene dependent, toileting dependent, shower dependent, upper body dressing dependent, personal hygiene-dependent; lower body dressing substantial assistance. Mobility: Roll left and right-dependent; Sit to lying-dependent; Lying to sitting on side of bed-dependent; Sit to stand-dependent; Chair/bed transfer-dependent; Toilet transfer-dependent; shower-dependent; incontinent of bowel & bladder; Medications-Antidepressant, Antiplatelet; Hospice Care; Occupational Therapy. Review of Care Plan revised 12/14/2021, for Resident #2 revealed, Cognitive Impairment r/t Alzheimer Dementia, impaired ability to make decisions, difficulty in expressing needs, impaired safety awareness. Potential for Injury r/t Actual falls, noncompliance with safety interventions, cognitive impairment, impaired safety-revised 06/12/2022. Require assistance with ADLs r/t cognitive deficits revised 08/01/2023. Potential for alteration in bleeding tendencies and increase bruising r/t use of anticoagulant/antiplatelet Aspirin revised 12/15/2021. Resident receiving Hospice Services r/t terminal disease COPD revised 07/21/2022. Episodes of adverse behaviors: Verbally aggressive-cursing, racial slurs, yelling/screaming; physically aggressive hitting staff or residents. Care plan did not address risk for falls. Review of Incident Report dated 04/05/2024 2:00 PM, written by LVN F for Resident #2 revealed, Resident #2 was agitated and aggressive this morning. After lunch time resident presented with a hematoma to her forehead. Resident was in room going through her personal belongings and roommate's drawers and closets. Resident was transferred to bed and CNA reported resident's resident's behaviors to LVN F. Head to toe assessment. Hospice of El Paso notified. Daughter [NAME] notified. MD notified. Hematoma to face. Predisposing Physiological Factors-confused and impaired memory. Witnesses: No witnesses found. Review of electronic progress notes dated 04/05/24 through 04/08/24 for Resident #2 revealed, Neuro checks had not been completed when resident was found with a hematoma and bruises around the eyes and on both cheeks. Review of Physician Order dated 04/08/2024, provided by DON for Resident #2 revealed, send resident to hospital via ambulance for a CT scan of the head. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Nursing Progress Note dated 04/08/2024 11:30 AM, written by LVN G, for Resident #2 revealed, resident was picked up via Ambulance to be transported to hospital to get CT scan of head and facial x-rays due to hematoma and scattered bruising to face. Family and DON was contacted about transport. Review of hospital CT scan report dated 04/08/24 at 2:23 PM, for Resident #2 revealed, Reason for Exam: Female, [AGE] years old. Trauma. Finding forehead scalp 1.5 x 2 cm diameter by 0.9cm thickness hematoma is seen. There is no intracranial hemorrhage. Impression: Right forehead scalp hematoma. Telephone interview on 04/23/24 at 10:39 AM, with LVN E on the evening shift revealed, revealed licensed staff had been trained to report changes in condition to the physician, FNP, responsible party, DON, ADON and MDS Nurses. The licensed staff were trained to document assessments, changes in condition/behaviors and notification of changes in condition in the electronic record and complete an SBAR form for any change in condition. The nurses were also trained to start Neuro checks for all unwitnessed falls or head injuries according to policy. Neuro checks were documented on the Neurological Assessment Flow Sheet. In an observation and interview on 04/24/24 at 11:33 PM, with LVN F on the day shift, revealed Resident #2 was in her room sitting in a wheelchair. The resident did not answer simple questions. It was observed the resident had fading, light purple bruising around the eye orbits down to her cheeks. LVN F stated, I was working on 04/05/24, when Resident #2 was found with the bump on her forehead the size of a quarter. The bump to her head was noted at approximately 1:30 PM on that day by the therapist. No other injuries were noted at the time of the assessment. LVN F reported that he and CNA H had seen Resident #2 forcefully opening & closing the closet doors and dresser drawers in her room and going through the dresser drawers. LVN F reported that on that day Resident #2 was agitated and was cursing. LVN F stated, I was working in the decentralized nurses' station that is close to Resident #2's room, and I heard loud banging of drawers, closet doors, and loud yelling. I went to the room to check and see if the Resident # 2 was OK. The door to the room was opened. It was already the end of the shift, and I was making the last round. CNA H was in the room attempting to calm down Resident #2. LVN F, stated, I assumed that Resident #2 got hit with the closet door on the face. The resident was not able to tell me what had happened. The resident was sitting in her wheelchair, was calm, and smiling at me. I assessed the resident and did not see any injuries at time of assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7441 Paseo Del Norte El Paso, TX 79911	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/24/24 at 12:03 PM, with CNA H, revealed that she worked on 04/05/24 on the morning shift and after breakfast heard someone yelling loudly and making a lot of noise. CNA stated, I walked down the hall and noticed the noise was coming from Resident #2's room. When I entered Resident #2's room she was by the window forcefully opening and forcefully closing the closet doors. The resident was also forcefully opening and closing the dresser drawers. The dresser drawers would bounce back and would slightly open when closed. I did not see resident get hit by the dresser drawers or the closet doors on that day. CNA H reported that she had left the room to allow [Resident #1] to calm down and went to report LVN F. CNA stated, In the evening, I was at the decentralized nurse's station feeding a resident when I saw one of the therapist's came to report to LVN F that Resident #2 had a bruise on forehead. I went to check the resident before the end of the shift and noted that she had a bruise on the forehead and down to the bridge of the nose. The next day when I returned to work on 04/06/24 on the day shift and noted Resident #2 had dark purple bruising on both eyes and on her cheeks. I remember that on that day, the hospice nurse came to see the resident. CNA H reported Resident #2 would take the clothes from the drawers and mix her clothes in her room mate's drawers and frequently refused care. CNA H stated they had been trained to report any behaviors immediately to the nurses. In a telephone interview on 04/24/24 at 5:59 PM with the COTA, revealed [Resident #2] was on hospice and was receiving occupational therapy. The COTA stated, I remember that on that day 04/05/24, I had not finished my therapy session and went later that afternoon to complete the therapy session. I wrote in my therapy notes that upon entering the room, I had noted [Resident #2] had a bruise on the forehead and immediately went to report this to LVN F on the morning shift. LVN F came to the room assessed the resident and said, it was a vein and not a bruise. The COTA agreed to email the surveyor a copy of the notes for 04/05/24. The therapy note was not emailed to the surveyor prior to exit on 04/24/24. Resident #4 Review of the Admission Record dated 04/23/24 at 5:02 PM for Resident #4, revealed, Original admitted : 01/18/2024. Review of History & Physical dated 01/22/2024, Resident #4 revealed, [AGE] year-old male Past Medical History: Diabetes Mellitus, hypertension, coronary artery disease, benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine), paroxysmal atrial fibrillation (when heartbeat returns to normal within 7 days on its own or with treatment), iron deficiency anemia and Dementia associated with alcoholism with behavioral disturbance. Review of the PPS 5-day Scheduled MDS dated [DATE], for Resident #4 revealed, hearing adequate; clear speech; makes self-understood; understands others; vision adequate; BIMS-score 2 (severely impaired); Functional Limitation in Range of Motion: Impairment on both sides - upper extremity. Wheelchair. Self-Care Assessment: Eating setup assistance, oral hygiene supervision, toileting substantial assistance, shower substantial assistance, upper body dressing substantial assistance, lower body dressing substantial assistance. Mobility: Roll left and right-substantial assistance; Sit to lying- substantial assistance; Lying to sitting on side of bed- substantial assistance; Sit to stand- substantial assistance; Chair/bed transfer- substantial assistance; Toilet transfer- substantial assistance; Indwelling catheter. incontinent of bowel; Falls since admission with no injury. Medications-antipsychotic; Speech/Occupational/Physical therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan, for Resident #4 revealed, revealed Stage II pressure ulcer to sacrum and DTI to right heel r/t history of ulcers and immobility revised 02/06/2024. Skin tear to left shin and right elbow r/t fragile skin revised 04/19/24. Care plan did not address ADL deficit; Use of anti-anxiety medication; Use of anti-psychotic mediation use; and Recurrence of falls. Review of the Physician's Order Active Order Summary dated 04/23/2024 for Resident #4 revealed, Hydroxyzine HCL 25 mg give 2 tablets by mouth every 24 hours as needed for agitation/anxiety at HS-order date 03/04/24. Pallperidone ER 1.5 mg give 2 tablets by mouth at bedtime for mood disorder-order date 02/21/24. Review of the Fall Risk assessment dated [DATE], for Resident #4 revealed, Score: 15. Category: High Risk. Mental Status: Intermittent confusion. History of Falls (past 3 months) 1-2 falls in past 3 months. Gait/Balance: Ambulatory/incontinent. Review of the Fall Risk assessment dated [DATE], for Resident #4 revealed, Score: 17. Category: High Risk. Mental Status Disoriented to person, place, and time. History of Falls (past 3 months) 3 or more falls in past 3 months. Ambulation/Elimination Status: Chair Bound - Requires restraints and assist with elimination. Gait/Balance: Decreased muscular coordination. Review of the Fall Risk assessment dated [DATE], for Resident #4 revealed, Score: 15. Category: High Risk. Mental Status: Disoriented to person, place, and time. History of Falls (past 3 months) 3 or more falls in past 3 months. Ambulation/Elimination Status; Chair Bound - Requires restraints and assist with elimination. Gait/Balance: Balance problems while standing. Review of the Fall Risk assessment dated [DATE],for Resident #4 revealed, Score: 13. Category: High Risk. Mental Status: Intermittent confusion. History of Falls (past 3 months) 1-2 Falls in past 3 months. Ambulation/Elimination Status; Chair Bound - Requires restraints and assist with elimination. Gait/Balance: Balance problems while standing. Review of the Fall Risk assessment dated [DATE], for Resident #4 revealed, Score: 13. Category: High Risk. History of Falls (past 3 months) 3 or more falls in past 3 months. Ambulation/Elimination Status; Chair Bound - Requires restraints and assist with elimination. Gait/Balance: Balance problems while standing. Review of the Incident Report dated 02/03/24 at 4:15 PM for Resident #4 written by LVN K, revealed, While walking in the hallway, I could hear knocking, when walked into room, observed resident lying on floor on his lateral right side. Half of his body was observed to be on the blue floor mat next to bed. Call device not activated; brief dry minus blood observed in front of brief. The resident stated he was trying to scoot off the bed. When asked if he hit his head, he stated, he hoped not. Injuries Observed at Time of Injury: Abrasion to chest. Mental Status: Pleasantly confused. Predisposing Physiological Factors: Confused, impaired memory. No witnesses found. There was no documentation of neuro checks being completed. Interview with the DON on 04/24/24 at 7:22 PM, revealed that she and her ADON had looked all over for the neuro checks for Resident #2 for the incident on 02/03/24 and did not find the Neurological Assessment Flow Sheet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Cimarron Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7441 Paseo Del Norte El Paso, TX 79911	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/24 at 10:54 PM, LVN A revealed Resident #4 was confused, required total care, had a suprapubic catheter, was incontinent of bowel, was turned & repositioned in bed every two hours and as needed. The resident had a history of falls and had a low bed with a floor mat to prevent injuries from falls. The nurse reported the resident did not have any behaviors. The resident was able to answer simple questions at times and he used his call light as needed. The nurse reported the resident would put his legs down on the side of the bed and did not attempt to stand up without assistance. Interview and record review of facility's policy and procedure on Head Injury dated October 2023, provided by the DON on 04/24/24 at 7:22 PM, revealed policy: It is the policy of this facility to report potential injures to the physician and implement interventions to prevent further injury. Policy Explanation & Guidance: Assess resident following a known, or verbalized head injury. Neurological evaluations for changes in: Physical functioning, behavior, level of consciousness, dizziness, nausea, irritability, and slurred speech or slow to answer questions. Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell, or bleeding. Notify physician and follow orders for care. Provide information from physical assessment. Describe how injury occurred and how situation has been managed so far; Report any recent medication changes or use of antiplatelet/anticoagulant m [TRUNCATED]