STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	07/27/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Residents #1, and #2) of 4 residents reviewed for call light placement. The facility failed to ensure that Residents #1, and #2 's call lights were within their reach. This failure placed residents at risk of not being able to call for assistance when needed. Findings included: Resident #1 Review of the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to our hospital due to fall. Patient had an accidental mechanical fall 2 days ago from her bed, when she rolled from her bed. Her left hand was caught in the handrail and landed on her left lower limb. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Hence, after discussion with her PCP, plan was to prescribe pain medication for her pain, but facility's pharmacy not opened at this time and hence was transferred to the hospital for pain management. Patient was still able to perform her ADLs by herself, but with pain. Baseline: She is wheelchair bound, able to transfer from bed to the chair and commode herself. She is still able to do so after the fall. Medical History: Acute UTI, Anxiety, Dementia, Lower back pain, osteoporosis, PVD (peripheral vascular disease). Review of the Quarterly MDS dated [DATE] for Resident #1 revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMS Score 06, (severely impaired), no behavior symptoms, wheelchair, ADLs-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Requires partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan revised 02/10/21 for Resident #1 revealed Cognitive Impairment-short term memory r/t dementia. Revised 06/26/24 Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: 12/12/23 Instruct resident to call for help before getting out of bed or chair. Always keep call light in reach, visible to resident and the resident is informed of its location and use. Interview on 07/08/24 at 8:43 AM, with LVN J, on the 6-2 shift revealed Resident #1 was alert, oriented to person and place, able to verbalize needs and was able to use the call-light for assistance. LVN reported rounds were made every two hours by Nurses and CNAs and the CNAs stayed at the decentralized station to monitor residents and answer call-lights while they were doing their charting. LVN reported Resident #1 was impulsive and required close supervision and re-direction because Resident #1 was able to transfer independently from bed to chair, had unsteady gait and toileted independently. Observation on 07/08/24 at 4:50 PM, revealed Resident #1 was propelling her wheelchair in her room with her hands and feet towards the bathroom and was attempting to open the bathroom door. The Enteral Feeding pump and portable oxygen cylinder were attached to the back of the wheelchair. The resident's call light was not on. The Surveyor immediately alerted CNA that was sitting at the decentralize station, that resident was attempting to open the door to the bathroom. The CNA immediately went to the room to assist the resident to the toilet. Interview on 07/08/24 at 4:58 PM, with LVN D on the 2-10 shift revealed, Resident #1 was alert, oriented to person, place, recognized familiar people, was able to verbalize needs and make decisions. LVN D reported Resident #1 at times would not use the call light and would bang on the wall with her hands or with a cup to call for assistance. LVN reported resident frequently attempted to toilet without assistance and required close supervision and re-direction, to prevent falls due to unsteady gait. Observation and interview at 07/09/24 at 6:09 AM, with LVN B on the 10-6 shift revealed, Resident #1 was lying in bed asleep and call light was not within reach. It was observed that the call light was on top of the nightstand by the side of the bed. LVN B immediately clipped the call light to the pillowcase. LVN B reported that prior to the incident on 06/22/24, Resident #1 was able to get in and out of bed by using the Grab Bar on the sides of the bed, had unsteady gait, was confused at times, oriented to person and place, recognized familiar people, and was able to verbalize needs. LVN stated Resident #2 occasionally uses the call light. LVN B stated, Resident #2 bangs on the wall with her hand and/or uses the call light when she needs assistance. LVN B reported nursing staff had been trained to place call-lights within reach and to check during scheduled rounds that are made every two hours or as needed that call lights are always within resident's reach. Interview on 07/09/24 at 11:22 AM with CNA A revealed, Resident #1 was alert, confused at times, was able to verbalize needs, was very impulsive, and frequently attempted to toilet without assistance. CNA reported Resident #1 required close supervision and re-direction to prevent falls due to unsteady gait. CNA A stated, We encourage the resident to go to the toilet when we go to her room during scheduled rounds. Resident #1 does not use the call light for assistance, she bangs on the wall with her hands or a cup when she needs assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/09/24 at 3:01 PM with DON, revealed Resident #1, was alert, confused at times, was able to verbalize needs at times. DON reported Resident #1 was able to use her call light when she needed assistance. DON reported nurses and CNAs made rounds every two hours and as needed to check the residents and call light placement. DON reported nursing staff had been trained to always place call lights within reach. Observation and interview on 07/09/24 at 3:28 PM, with family member revealed Resident #1 was able to use the call light for assistance. Family member reported the staff took a long time to answer Resident #1's call light, so the resident would bang on the walls with her hands or whatever she could get to call for assistance. Family member stated, Look, that why the paint on the wall on the right side of the bed is scraped due to Resident #1 hitting the wall with her cup or remote control to call for assistance. Family member reported resident's call light was not always within reach when she came to visit the resident. Observation and interview on 07/10/24 at 9:18 AM, revealed Resident #1 was sitting in her wheelchair in her room, was oriented to person and was able to answer simple questions. Resident did not recall having a fall. Resident reported that she used the call light to call for assistance. Resident's call light was clipped on the side of the bed and was within reach. Resident #2 Review of the Admission Record dated 07/08/24 at 5:30 PM revealed, Resident #2 was initially admitted on [DATE] and readmitted [DATE]. Review of the Annual History & Physical dated 08/01/23 revealed Resident #2' was an [AGE] year-old female with diagnoses of hypertension, dementia, anxiety, epilepsy, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), stenosis of peripheral vascular stent (A stent is a permanent device that's inserted to keep blood flowing) stable (stenosis is a narrowing of the arteries in the legs and feet, malignant epithelial neoplasm of vulva (a cancer of the external genitals), encephalopathy (is a serious neurological condition that occurs when the brain is damaged or diseased causing brain function to change), Alert, oriented to person. Review of the Quarterly (MDS) dated [DATE] for Resident #2, revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMS Score 05, (severely impaired), no behavior symptoms, wheelchair, ADLs-toileting supervision or touching assistance; extensive to moderate assistance with sit to lying, sit to stand, chair/bed transfer, shower transfer; always incontinent of bowel & bladder; active diagnoses-heart failure, hyponatremia, non-Alzheimer's dementia, epilepsy, depression, encephalopathy; repeated falls; no pain; medications-antianxiety, antidepressant, hypnotic. Review of the Care Plan Revised 03/27/24 for Resident #2, revealed she require assist with ADLs and at risk for deterioration ADLs r/t cognitive deficits, physical impairment, behaviors. Interventions: always keep call light in reach, and visible. Inform me of its location and use. Answer promptly. Revision on 03/27/24 Communication Problems related to Cognitive Communication Disorder (difficulty in paying attention to a conversation, staying on topic, remembering information, responding accurately, or following instructions). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/08/24 at 4:52 PM, with LVN D, revealed Resident #2 required total assistance of one person with ADLs, was incontinent of bowel and bladder. Resident was lying in bed awake and did not answer simple questions. Resident just stared at the surveyor and the nurse and would not answer questions. LVN D reported Resident #2 could voice simple needs at times such as when she wanted to go back to bed or was having pain. It was observed that call light was clipped to the pillowcase. LVN D reported resident used the call light at times and yelled for assistance most of the time. Observation and Interview on 07/10/24 at 9:22 AM, revealed CNA A entered Resident #2's room, the resident was sitting in her wheelchair by the side of the bed and call light was not within reach. There was a pillow on top of the nightstand, directly behind the resident's wheelchair and the call light was attached to the pillow. CNA reported that resident occasionally used the call light to call for assistance. Resident usually yells out for assistance. CNA A immediately placed the call light within reach by clipping the call light to the side of the bed. CNA stated, I just went in to check on the resident, and that is when I noted that the call light was not within reach. We have been trained to always keep the call lights within reach so the residents can call for assistance as needed. Surveyor requested copy of call light policy. The policy was not provided prior to exit.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interview and record review the facility failed to allow the resident to obtain a copy of the records upon request and upon two working days advance notice to the facility for 2 of 6 residents (Resident #2 and Resident #5) whose records were reviewed in that: -The facility failed to provide Resident #5's legal representative copies of medical records after a request was submitted to the facility. - The facility failed to provide Resident #2's family member a copy of the EKG report. This failure could place residents at risk of violation of their rights by not receiving copies of their medical records. The findings were: Resident #5 Closed Record Review of Admission Record dated 07/10/24 at 9:44 AM, for Resident #5 revealed an original admitted [DATE]. Responsible Party was listed as family member. Resident was transferred to the hospital via EMS on 04/28/24. Review of the Medical Visit dated 03/18/23 for Resident #5 revealed Reason for visit: Initial Visit. [AGE] year-old-female, transferred from hospital where she was treated for cellulitis and decubitus ulcer. Transferred to facility to resume her rehabilitation. Past Medical History chronic paraplegia (paralysis that affects the legs) s/p motor vehicle accident over [AGE] years ago, hypertension, History of DVT (deep vein thrombosis). Alert, oriented to person, place, and time. Review of the admission MDS dated [DATE] for Resident #5 revealed, hearing adequate, clear speech, makes self-understood, understands others, vision adequate, BIMS score 15 (cognitively intact), ADLs extensive assistance of two persons with bed mobility, transfers, dressing, and toilet use; extensive assistance of one person with locomotion on/off unit; supervision with eating and personal hygiene; Balance during transitions-Surface-to-surface transfer 2- not steady, only able to stabilize with staff assistance; wheelchair; indwelling catheter, Ostomy. Review of the Care Plan revised on 11/09/23 for Resident #5 revealed, Date initiated 04/28/23 I do not require discharge planning as my family plans are to stay LTC until my daughter think is appropriate for me to go home if possible. I desire to remain in the facility and receive assist with my care. Review of an email dated 06/15/24 at 7:52 PM, From: DON. To: Medical Records Clerk regarding Resident #5 revealed, Subject: Record Request/Legal documentation etc. Follow Up Flag: Medical Records Clerk, please follow up ASAP. Review of attached email dated 06/14/24 at 11:32 AM From: Corporate Admin. Subject: Record Request/Legal documentation etc. We are already past the date on these documents. This is a request to determine guardianship. We need to send the documents. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an email dated 04/11/24 for Resident #5 revealed, legal representative had sent email to facility Administrator. By certified letter dated July 5, 2023, we sent notice to the Administrator at facility requesting a complete record for Resident #5 of her entire admission to facility that includes the date of 4/27/23 (including all Nurses' and PT Notes). Enclosed please find a copy of the medical release signed by Resident #5. Also enclosed is a signed HIPAA release for Resident #5. We sent follow up letters on 8/17/23 and 10/11/23. Hand delivered a follow up letter on 12/12/23, and then sent an email on January 8, 2024. Since January 2024, have sent multiple emails and spoken with current Administrator about facility's utter failure to provide records, as required by Texas Law and HIPAA. To date, facility has failed to provide the requested medical records for Resident #5 from your facility. Review of U.S. Portal Service Certified Mail Receipt for Resident #5 revealed, received by Receptionist on 07/07/23. Review of the Authorization Form for Release of Protected Health Information for Resident #5 revealed form was signed by resident, on 06/12/23. Review of emails sent to facility regarding Resident #5's Record Requests revealed: -Email dated 01/08/24 at 12:00 PM, sent by #5's legal representative to ABOM (Assistant Business Office Manager) revealed, Good morning. I spoke to Assistant Office Business Manager a few minutes ago. Please contact me to provide your medical records for Resident #5. -Email dated 02/28/24 at 3:10 PM, sent to former Administrator: Since July 2023, facility has failed to respond to several letters asking for medical records for Resident #5. I left a message today with your receptionist, asking that you call me. I was told that you were in a meeting. -Email dated 03/19/24 at 2:07 PM, sent to former Administrator regarding Resident #5's record request revealed, despite our telephone discussion on March 6,2024, I still do NOT have my client's medical records from your corporate office. -Email dated 04/01/24 at 5:29 PM, sent to Administrator regarding Resident #5's record request revealed, As of April 1, 2024, your company STILL has not provided the medical records to me. I really don't understand this. Please contact me about this. -Email dated 04/08/2 at 11:37 AM, sent to Administrator regarding Resident #5's record request revealed, please state the name and address of your corporate supervisor/contact, so I may contact them about the FAILURE to comply with Texas Law and HIPAA to produce my client's medical records for me. This is a serious situation, that will be addressed to Medicare and Texas Department of Aging and Disability. Review of the electronic Nurse's Progress Note dated 04/28/24 at 11:45 AM, written by former DON revealed Resident's Responsible Party informed of radiology results. Family member informed of orders for pain and an orthopedic consult and was not satisfied with physician's orders. Family member stated, You have to send her to the ER right now. Telephone placed on 07/09/24 at 3:00 PM, to Resident #5's responsible party, no answer, left message to call surveyor back. Return call was not received prior to exit. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/09/24 at 3:03 PM, with Receptionist C revealed that she did not remember talking to anyone about a records request for Resident #5. Interview on 07/09/24 at 3:09 PM, with the Assistant Business Office Manager revealed she did not recall talking to anyone or receiving an email regarding records request for Resident #5. Interview on 07/10/24 at 9:43 AM, with the Medical Records Clerk, revealed Resident #5 was discharged from the facility May 2023. He reported that 2 weeks ago, a family member had called to let him know that her lawyer was requesting a copy of the medical records for Resident #5. The family member did not voice any concerns. He stated, I immediately forwarded an email to Risk Management at Corporate Office regarding medical records request. I am awaiting instructions of what I need to do with this request. Surveyor requested a copy of Policy & Procedure on Release of Medical Records. He reported that he had been informed by the DON, on 07/09/24 of the records request for Resident #5. He stated that he was not aware if previous requests had been made by Resident #5's family member requesting copies of the medical record. He reported that he had immediately contacted family member to report that they were working on her request to obtain copies of the Medical Record. Interview on 07/10/24 at 10:07 AM with the DON revealed, the former Administrator had never processed the request for Medical Records for Resident #5. The DON stated, I found out today, that the former Administrator had never sent the request for Medical Records to Corporate office. Telephone interview on 07/12/24 at 2:35 PM with the former Administrator, reported her last day of work at the facility was May 14, 2024. The Administrator stated, I remembered getting a medical records request for Resident #5 but I do not remember who made the request or if I sent the request to Risk Management at corporate office so they could process the request. Resident #2 Review of the Admission Record dated 07/08/24 at 5:30 PM revealed, Resident #2 was initially admitted on [DATE] and readmitted [DATE]. Review of the Annual History & Physical dated 08/01/23 for Resident #2 revealed [AGE] year-old female with diagnoses of hypertension, dementia, anxiety, epilepsy, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), stenosis of peripheral vascular stent (A stent is a permanent device that's inserted to keep blood flowing) stable (stenosis is a narrowing of the arteries in the legs and feet, malignant epithelial neoplasm of vulva (a cancer of the external genitals), encephalopathy (is a serious neurological condition that occurs when the brain is damaged or diseased causing brain function to change). Alert, oriented to person. Review of the Quarterly MDS dated [DATE] for Resident #2, revealed Atherosclerosis with unspecified Angina Pectoris (Thickening or hardening of the arteries, with chest pain or discomfort when heart muscle does not get enough blood). (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan Revised 03/27/24 for Resident #2, revealed she require assist with ADLs and at risk for deterioration ADLs r/t cognitive deficits, physical impairment, behaviors. Interventions: always keep call light in reach, and visible. Inform me of its location and use. Answer promptly. Revision on 03/27/24 Communication Problems related to Cognitive Communication Disorder (difficulty in paying attention to a conversation, staying on topic, remembering information, responding accurately, or following instructions). Review of the Physician Order Summary Report dated July 08, 2024, for Resident #2 revealed Order Range: 04/01/24 - 07/31/24. -Order Date: 07/03/24 STAT EKG [sic] for irregular heartbeat. In a telephone interview on 07/08/24 at 8:08 AM, with family member revealed LVN J had called her to give her the results of the EKG at which time she requested a copy of the EKG and asked LVN J to send it to my email. Interview and record review on 07/09/24 at 9:08 AM, with LVN J revealed that family member, had requested that he send her a copy of the EKG results to her email. He stated that he had not reported this request to the DON and/or Medical Records Clerk. LVN J stated he had not documented the change in condition and MD/family notification in the resident's electronic record. LVN stated, I know that I wrote a note in the electronic progress notes but can't find it. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy & procedure on Release of Medical Records implemented 07/22/23, revealed Policy: Medical records will be released with a valid request and in accordance with state and federal laws. Policy Explanation and Compliance Guidelines: Request for records should be referred to the Director of Nursing or Administrator, or another staff member. Upon request to access or obtain copies of the medical record, the facility should review the authorization to ascertain access rights of that person. Authority to access or release records is only granted by the resident or the resident's legal representative. The facility should request copies of any legal papers necessary to authenticate authority. The legal papers should be attached to the request for records. A valid request for medical information concerning a resident, by a party other than the resident, includes Name of resident. Name and address of facility, Name, and address of individual or organization requesting information. Specific information and reports requested. Period of stay for which information is to be released. Date of request. Signature of the resident or legally appointed representative authorizing release of information. The corporate office/risk manager should be notified of the request for records. Records should not be released prior to discussion with the corporate office/risk manager, to further validate authenticity of the request. Upon receipt of a request for medical record copies, the facility should notify the requesting party, in writing, of the cost for obtaining records and that records are available 2 days after receipt of payment for the copies. Copies should not be released prior to the receipt of payment for copying charges. Once a request for records is received, all records for that resident should be gathered and secure in a place inaccessible to anyone except the Administrator, Director of Nursing, or designee. Once the record is assembled, it should be reviewed to ensure inappropriate records have not been included. If the resident wishes to access their medical records via electronic means, the facility will release those records in a secure, electronic format as deemed per their IT department and/or software security means for accessing records. The facility should respond to any subpoena for medical records in the same manner as a request for records by the resident, family, or attorney. The subpoena, however, may have a different time frame for production of records. When the subpoena is issued on behalf of the resident or legal representative, the records should be released according to this policy. When the subpoena is issued on behalf of a non-legal representative, then the facility should respond to the subpoena according to the type of subpoena.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 two (Resident #2 and Resident #3) of six residents reviewed for physician notification. -The facility failed to immediately consult with physician and/or Nurse Practitioner when the facility did not have 7 doses of the prescribed IV antibiotics on hand to administer to Resident #2 according to physician's orders. -The facility failed to immediately consult with physician and/or Nurse Practitioner when the facility did not have 8 doses of the prescribed IV antibiotics on hand to administer to Resident #3 according to physician's orders. This failure could place residents at risk of delayed medical treatment. Findings include: Resident #2 Review of the Admission Record dated 07/08/24 at 5:30 PM revealed, Resident #2 was initially admitted on [DATE] and readmitted [DATE]. Review of the Annual History & Physical dated 08/01/23 for Resident #2 revealed an [AGE] year-old female with diagnoses of hypertension, dementia, anxiety, epilepsy, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), stenosis of peripheral vascular stent (A stent is a permanent device that's inserted to keep blood flowing) stable (stenosis is a narrowing of the arteries in the legs and feet, malignant epithelial neoplasm of vulva (a cancer of the external genitals), encephalopathy (is a serious neurological condition that occurs when the brain is damaged or diseased causing brain function to change), Alert, oriented to person. Review of the Quarterly MDS dated [DATE] for Resident #2, revealed Atherosclerosis with unspecified Angina Pectoris (Thickening or hardening of the arteries, with chest pain or discomfort when heart muscle does not get enough blood). Incontinent of bowel & bladder. Review of the Care Plan revised 06/27/23 for Resident #2 revealed, At Risk for UTIs (Urinary Tract Infection) r/t incontinent of bowel & bladder due to poor cognition. Interventions: Administer meds per MD order. Review of the Physician Order Summary Report dated July 08, 2024, for Resident #2 revealed Order Range: 04/01/24 - 07/31/24. -Order Date: 06/14/24. Start Date: 06/15/24 Clindamycin Phosphate in NaCl (sodium chloride) intravenous solution 300-0.9 mg/50 ml intravenously three times a day for UTI infection for 7 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	-Order Date: 06/17/24. Start Date: 06/17/24 Clindamycin HCl Oral Capsule 300 mg give 1 capsule by mouth three times a day for UTI for 10 days. Review of the electronic Nurses Progress Notes for Resident #2 revealed: -06/14/24 at 9:41 PM INTERACT SBAR Summary form (provides a framework for communication between health care team about a patient's condition) written by LVN D documented Clindamycin 300 mg IV 3 x a day for 7 days for UTI. -06/15/24 at 12:59 PM note written by LVN E documented, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available. -06/15/24 at 5:39 PM note written by LVN E documented, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. -06/15/24 at 7:27 PM note written by LVN E documented, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. Record Review revealed the facility did not have written documentation in Resident #2's electronic Nurses Progress Notes that documented attending physician and/or NP were notified Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) was not available to administer according to physician's order on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. Review of the MAR dated June 2024 for Resident #2 revealed: -Order Date: 06/14/24 for Clindamycin Phosphate 300-0.9 mg/50 ml in sodium chloride solution intravenously three times a day for UTI for 7 days. MAR documented medication was not administered on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. IV Clindamycin Phosphate was discontinued on 06/17/24 and was changed on 06/17/24 to Clindamycin HCL 300 mg give 1 capsule by mouth three times a day for UTI x 10 days. Telephone interview on 07/08/24 at 7:43 AM, with family member for Resident #2 revealed, that the nurses do not given Resident #2 her medications as ordered by the physician. Interview and record review at 07/10/24 at 7:19 AM, with the DON revealed facility did not have an order in the Resident #2's electronic record for a UA. The DON stated, The Nurses have been trained to immediately notify physician or Nurse Practitioner of changes in condition. The nurses must get a doctor's order for labs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 07/10/24 at 7:35 AM, with the DON, stated, It took 3 days for the nurses to call the physician and report that Clindamycin IV had not been given as ordered and change the Clindamycin from IV to PO. There is no excuse. The Nurses should have notified the physician or the NP, right away to let them know that the pharmacy had not delivered the Clindamycin IV as ordered. The nurses have been trained to immediately notify the physician and NP if the medications are not in the E-Kit or if the pharmacy has not delivered the prescribe medication to administer as ordered. The nurses have been trained to document this in the resident's clinical records. I do not know why the nurses failed to document in the resident's clinical record. Telephone interview on 07/10/24 at 8:50 AM, with attending physician for Resident #2 revealed, that he expected the licensed staff to report to physician and/or NP if the prescribed medication had not been administered as ordered due to the lab not coming to draw blood for ordered labs and/or not sending lab results on a timely basis to determine Vancomycin IV can be administered as ordered. The Physician stated that licensed staff cannot order labs without a physician's order. The physician stated The licensed staff should immediately notify physician and/or the NP of a change in condition at which time a decision will be made if labs will need to be ordered, depending on the resident's change in condition. It is very important that labs results are obtained as soon as possible to ensure that medical treatment is not delayed. Confidential interview on 07/11/24 at 11:01 AM, revealed Resident #2 had a physician order for Clindamycin IV to treat a UTI. The medication was not given as ordered because the medication was not delivered by the pharmacy and the medication was not on hand in the Emergency Kit. It was reported that the lab did not come on a timely basis to draw blood for the ordered labs and the IV medication could not be administered until labs have been done and results have been received and reported to physician. Resident #3 Closed Record review of Admission Record dated 07/09/24 for Resident #3 revealed, original admitted : 06/06/24. Resident discharged home on 07/08/24 with Home Health Services. Review of the Initial Medical Visit dated 06/10/24 for Resident #3 revealed, [AGE] year-old-female discharged from hospital where she was treated for right knee septic arthritis (is a painful infection in a joint that can come from germs that travel through your bloodstream from another part of your body) for which patient underwent a Right knee irrigation and debridement (a process of removing dead skin and foreign material from a wound) on 05/25/24. The patient continues with Vancomycin 1000 mg/200 ml BID and Ceftriaxone 2 GM QD (daily) through PICC line (a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near your heart) to RUE (Right Upper Extremity). Active Medical Problems: Hypertension, Diabetes Mellitus type 2, Right knee irrigation and debridement on 05/25/24, Right knee arthroplasty (a surgery to restore the function of a joint) 06/20/23. Review of the Medical Visit dated 06/12/24 for Resident #3 revealed she underwent right knee arthrotomy (is a surgical exploration of a joint) with debridement and synovectomy with poly insert exchange (surgical removal of the membrane that lines a joint). Patient also seen by ID (Infectious disease doctor) recommending continue IV antibiotic for 6 weeks. Patient was admitted to our facility for PT and rehab. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS dated [DATE] for Resident #3, revealed clear speech, makes self-understood, understands others, vision adequate, BIMS Score 15 (Cognitively Intact), wheelchair, occasionally incontinent of bowel & bladder; other major orthopedic surgery; surgical wounds; antibiotic; IV medications. Review of the Care Plan revised on 07/09/24 for Resident #3, revealed Resident was on IV (giving medicines or fluids through a needle or tube inserted into a vein) medications. Revised 07/09/24 Resident was on antibiotic therapy. Interventions: Administer ANTIBIOTIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Report pertinent lab results to MD. Review of the Grievance/Complaint Report dated 06/26/24 for Resident #3 written by Social Worker revealed, Documentation of Grievance/Complaint related to Nursing Care. Resident stated that nursing staff are inconsistent with providing her antibiotics. Summary/Findings written by DON on 06/26/24 revealed, medication required labs prior to every 3rd dose. Medication may change depending on results. Recommendations/Action Taken continue to draw labs as ordered and give medication. Resolution of Grievance/Complaint Was grievance/complaint resolved? No. Family feels we should give medication at 8 AM and 8 PM regardless. Identify the method(s) used to notify the resident and/or representative of the resolution: Phone conversation. Review of the Physician Order Summary Report dated 07/09/24 at 3:08 PM, Order Date Range: 05/01/24 - 07/31/24 for Resident #3 revealed: -Order Date: Vanco trough every Friday. (A trough level is the concentration reached by a drug immediately before the next dose is administered, often used in therapeutic drug monitoring.) -Order Date: 06/06/24 Vancomycin HCl (antibiotic to treat bacterial infections) intravenous solution 1000 mg/200 ml every 12 hours for infection to surgical wound. -Order Date: 06/13/24 Vancomycin HCl intravenous solution 1250 mg/250 ml every 12 hours for infection to surgical wound. -Order Date: 06/18/24 Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection). -Order Date: 06/24/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. -Order Date: 06/27/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/09/24 at 3:59 PM, LVN F, reported Resident #3 was at the facility for a very short stay and was discharged back home. Resident was alert and oriented to x 4, she was admitted for IV antibiotics, status post-surgery to right knee, hardware got infected. LVN F stated, We had issues with the Lab not sending the trough level results on a timely basis, which delayed timely delivery of the IV antibiotic. The resident also went out on frequent 4 hours passes with her family. The family member was very upset because the resident had missed the morning dose of the IV antibiotic. The family could not understand that the blood work needed to be done prior to administering the next dose of the IV medication so the dosage could be adjusted as need and could not understand that they could not double up on missed doses, because the medication was very toxic to the kidneys. LVN F stated DON and ADON were aware that they were having problems with the Lab not coming to draw blood as ordered and/or Lab results not sent to facility on a timely basis resulted in residents not getting prescribed antibiotics as ordered. Telephone interview on 07/10/24 at 8:50 AM, with the attending physician for Resident #3 revealed, that he expected the licensed staff to report to physician and/or NP if the prescribed medication had not been administered as ordered due to the lab not coming to draw blood for ordered labs and/or not sending lab results on a timely basis to determine Vancomycin IV can be administered as ordered. The Physician stated that licensed staff cannot order labs without a physician's order. The physician stated The licensed staff should immediately notify physician and/or the NP of a change in condition at which time a decision will be made if labs will need to be ordered, depending on the resident's change in condition. It is very important that labs results are obtained as soon as possible to ensure that medical treatment is not delayed. Interview and record review on 07/12/24 at 2:53 PM, with Social Worker revealed, she had talked to Resident #3 about her not getting her prescribed antibiotic as ordered. Social Worker stated, I do not know why she was not getting her medication as ordered. Interview and Record Review of electronic Nurses Progress Notes on 07/12/24 at 3:01 PM with the ADON for Resident #3 revealed IV antibiotic was not administered according to physician's orders due to lab results not received on time when the Vancomycin was scheduled to be administered and/or pending delivery from the pharmacy. ADON stated, That is why we are changing labs, because labs were not done on a timely basis or lab results were not received on a timely basis. The ADON confirmed that the facility did not have any written documentation in Resident #3's electronic Nurses Notes that documented physician was notified medication was not administered as ordered due to not having the medication on hand and/or labs not done on a timely basis and/or not receiving lab results on a timely basis to determine the dosage for the next medication administration. ADON reported Nurses had been trained to immediately notify the attending physician/NP/DON/ADON if medications were not administered as ordered and to document the notification in the Nurse's Progress Notes. The MAR revealed: -06/11/24 at 8:08 PM written by LVN F, revealed, pending delivery from pharmacy, couldn't send until the [sic] had result of the Vanco trough. -06/13/24 revealed facility did not have any written documentation in the nurse's progress notes by LVN F that documented Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/14/24 10:38 PM written by LVN F revealed, Vancomycin HCl intravenous solution 1250/250 ml for Osteomyelitis. Medication not available, pending delivery. -06/18/24 at 9:00 PM, revealed facility did not have any written documentation in the nurse's progress notes by LVN F that documented Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered. -06/19/24 at 7:32 AM, written by LVN G revealed, Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Pending delivery. -06/21/24 at 3:13 PM, written by LVN F revealed, writer obtained results of Vanco trough that was drawn during previous shift and faxed them to the pharmacy twice. Pharmacy employee stated to ADON for the 300 hall [sic] that the results had not been received, when ADON asked if she could provide a verbal result, pharmacy employee stated she (ADON) would have to be transferred to the IV department. ADON did not receive an answer but left a message for an individual in the IV department named [NAME]. Results were faxed a third time by the ADON, pending response. -06/21/24 at 9:06 PM, written by LVN F, revealed, Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Increase to medication dose, pending delivery. -06/26/24 at 8:38 PM, written by LVN F, revealed, Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee two times a day. Pending delivery of possible dose change. -06/27/24 at 10:31 AM, Note Text written by LVN G revealed, this order is outside of the recommended dose or frequency. Vancomycin HCl 1750 mg/350 ml intravenously two times a day for infection to the right knee. This dose fails a general dose range check based on drug inputs and/or patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required. Interview and record review 07/12/24 at 3:07 PM with ADON confirmed LVN G had initialed the MAR on 06/27/24 at 8:00 AM. ADON stated, I am not able to determine if Vancomycin HCl 1750 mg/350 ml intravenously was administered. There is no documentation in the resident's electronic Nurse's Progress Note that LVN G notified the physician, that medication was outside of recommended dose. -07/06/24 at 2:58 PM written by LVN H revealed, Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee not given pending delivery from pharmacy. Review of the facility's undated policy & procedure on Notification of Changes revealed, Policy: The purpose of this policy is to ensure that facility promptly informs the resident, consults with the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring information. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include Accidents resulting in injury, potential to require physician intervention. Significant change in the resident's physical, mental or psychological condition such as deterioration in health, mental or psychological status. Circumstances that require a need to alter treatment. This may include new treatment. Discontinuation of current treatment due to: Adverse consequences, Acute condition, Exacerbation of a chronic condition. Competent individuals: The facility must still contact the resident's physician and notify resident's representative if known. A family that wishes to be informed would designate a member to receive calls.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interview and record review, the facility failed to ensure the prompt resolution of all grievances to include all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed, any corrective action or to be taken by the facility as a result of the grievance, and the date when the decision was issued for 1 of 6 (Resident #3) reviewed for resident rights. -The facility failed to ensure prompt resolution when Resident #3 was not administered 8 doses of the prescribed IV antibiotics according to physician's orders. These failures could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Resident #3 Closed Record review of the Admission Record dated 07/09/24 for Resident #3 revealed, original admitted : 06/06/24. Resident discharged home on 07/08/24 with Home Health Services. Review of the Initial Medical Visit dated 06/10/24 for Resident #3 revealed, [AGE] year-old-female discharge form hospital where she was treated for right knee septic arthritis (is a painful infection in a joint that can come from germs that travel through your bloodstream from another part of your body) for which patient underwent a Right knee irrigation and debridement (a process of removing dead skin and foreign material from a wound) on 05/25/24. The patient continues with Vancomycin 1000 mg/200 ml BID and Ceftriaxone 2 GM QD (daily) through PICC line (a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near your heart) to RUE (Right Upper Extremity). Active Medical Problems: Hypertension, Diabetes Mellitus type 2, Right knee irrigation and debridement on 05/25/24, Right knee arthroplasty (a surgery to restore the function of a joint) 06/20/23. Review of the Medical Visit dated 06/12/24 for Resident #3 revealed she underwent right knee arthrotomy (is a surgical exploration of a joint) with debridement and synovectomy with poly insert exchange (surgical removal of the membrane that lines a joint). Patient also seen by ID (Infectious disease doctor) recommending continue IV antibiotic for 6 weeks. Patient was admitted to our facility for PT and rehab. Review of the Admission MDS dated [DATE] for Resident #3, revealed clear speech, makes self-understood, understands others, vision adequate, BIMs Score 15 (Cognitively Intact), wheelchair, occasionally incontinent of bowel & bladder; other major orthopedic surgery; surgical wounds; antibiotic; IV medications. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revised on 07/09/24 for Resident #3, revealed Resident was on IV (giving medicines or fluids through a needle or tube inserted into a vein) medications. Revised 07/09/24 Resident was on antibiotic therapy. Interventions: Administer ANTIBIOTIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Report pertinent lab results to MD. Review of the Grievance/Complaint Report dated 06/26/24 for Resident #3 written by Social Worker revealed, Resident reported that nursing staff were inconsistent with providing her IV antibiotics. Summary/Findings written by DON on 06/26/24 revealed, medication required labs prior to every 3rd dose. Medication may change depending on results. Recommendations/Action Taken continue to draw labs as ordered and give medication. Resolution of Grievance/Complaint Was grievance/complaint resolved? No. Family feels we should give medication at 8 AM and 8 PM regardless. Identify the method(s) used to notify the resident and/or representative of the resolution: Phone conversation. Review of the Physician Order Summary Report dated 07/09/24 at 3:08 PM, Order Date Range: 05/01/24 - 07/31/24 for Resident #3 revealed: -Order Date: Vanco trough every Friday. (A trough level is the concentration reached by a drug immediately before the next dose is administered, often used in therapeutic drug monitoring.) -Order Date: 06/06/24 Vancomycin HCl (antibiotic to treat bacterial infections) intravenous solution 1000 mg/200 ml every 12 hours for infection to surgical wound. -Order Date: 06/13/24 Vancomycin HCl intravenous solution 1250 mg/250 ml every 12 hours for infection to surgical wound. -Order Date: 06/18/24 Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection). -Order Date: 06/24/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. -Order Date: 06/27/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. Interview on 07/09/24 at 1:58 PM, with Administrator from sister facility at 1:58 PM, revealed he was covering for facility's administrator who was on vacation. The Administrator reported the Administrators were designated as the Grievance Official at the facility and were responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigation by the facility. It was reported that the Administrator was on vacation since last week and he was not aware of the Grievance regarding missed doses of IV medications for Residents #2 and #3 due to labs not being done on a timely basis and/or medications not being on hand. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/09/24 at 3:59 PM, LVN F, reported Resident #3 was at the facility for a very short stay and was discharged back home. Resident was alert and oriented to x 4, she was admitted for IV antibiotics, status post-surgery to right knee, hardware got infected. LVN F stated, We had issues with the Lab not sending the trough level results on a timely basis, which delayed timely delivery of the IV antibiotic. The resident also went out on frequent 4 hours passes with her family. The family member was very upset because the resident had missed the morning dose of the IV antibiotic. The family could not understand that the blood work needed to be done prior to administering the next dose of the IV medication so the dosage could be adjusted as need and could not understand that they could not double up on missed doses, because the medication was very toxic to the kidneys. LVN F stated DON and ADON were aware that they were having problems with the Lab not coming to draw blood as ordered and/or Lab results not sent to facility on a timely basis resulted in residents not getting prescribed antibiotics as ordered. Telephone interview on 07/10/24 at 8:50 AM, with attending physician revealed, that he expected the licensed staff to immediately notify him and/or the Nurse Practitioner, when prescribed medications were not available to administer as ordered, so another medication can be prescribed to treat the resident as soon as possible. Physician reported that he was not aware that Resident #3 had missed several doses of the Vancomycin IV because the medication was not on hand to administer as ordered. The physician stated, The licensed staff need to report to physician and/or Nurse Practitioner if the prescribed medications were not administered as ordered due to the lab not coming to draw blood and/or not sending lab results on a timely basis. This is very important, so that there is no delay in medical treatment. Interview and record review on 07/12/24 at 2:53 PM, with the Social Worker revealed, she had talked to Resident #3 about her not getting her prescribed antibiotic as ordered. The Social Worker stated, I do not know why she was not getting her medication as ordered. Interview and Record Review of electronic Nurses Progress Notes at 07/12/24 at 3:01 PM with ADON for Resident #3 revealed IV antibiotic was not administered according to physician's orders due to lab results not received on time when the Vancomycin was scheduled to be administered and/or pending delivery from the pharmacy. ADON stated, That is why we are changing labs, because labs were not done on a timely basis or lab results were not received on a timely basis. The ADON confirmed that the facility did not have any written documentation in Resident #3's electronic Nurses Notes that documented physician was notified medication was not administered as ordered due to not having the medication on hand and/or labs not done on a timely basis and/or not receiving lab results on a timely basis to determine the dosage for the next medication administration. ADON reported Nurses had been trained to immediately notify the attending physician/NP/DON/ADON if medications were not administered as ordered and to document the notification in the Nurse's Progress Notes. The MAR revealed: -06/11/24 at 8:08 PM written by LVN F, revealed, pending delivery from pharmacy, couldn't send until the [sic] had result of the Vanco trough. -06/13/24 revealed facility did not have any written documentation in the nurse's progress notes by LVN F that documented Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/14/24 10:38 PM written by LVN F revealed, Vancomycin HCl intravenous solution 1250/250 ml for Osteomyelitis. Medication not available, pending delivery. -06/18/24 at 9:00 PM, revealed facility did not have any written documentation in the nurse's progress notes by LVN F that documented Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered. -06/19/24 at 7:32 AM, written by LVN G revealed, Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Pending delivery. -06/21/24 at 3:13 PM, written by LVN F revealed, writer obtained results of Vanco trough that was drawn during previous shift and faxed them to the pharmacy twice. Pharmacy employee stated to ADON for the 300 hall [sic] that the results had not been received, when ADON asked if she could provide a verbal result, pharmacy employee stated she (ADON) would have to be transferred to the IV department. ADON did not receive an answer but left a message for an individual in the IV department named [NAME]. Results were faxed a third time by the ADON, pending response. -06/21/24 at 9:06 PM, written by LVN F, revealed, Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Increase to medication dose, pending delivery. -06/26/24 at 8:38 PM, written by LVN F, revealed, Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee two times a day. Pending delivery of possible dose change. -06/27/24 at 10:31 AM, Note Text written by LVN G revealed, this order is outside of the recommended dose or frequency. Vancomycin HCl 1750 mg/350 ml intravenously two times a day for infection to the right knee. This dose fails a general dose range check based on drug inputs and/or patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required. Interview and record review 07/12/24 at 3:07 PM with ADON confirmed LVN G had initialed the MAR on 06/27/24 at 8:00 AM. ADON stated, I am not able to determine if Vancomycin HCl 1750 mg/350 ml intravenously was administered. There is no documentation in the resident's electronic Nurse's Progress Note that LVN G notified the physician, that medication was outside of recommended dose. -07/06/24 at 2:58 PM written by LVN H revealed, Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee not given pending delivery from pharmacy. Review of the facility's policy & procedure implemented 07/20/22 on Resident and Family Grievances revealed, Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator has been designated as the Grievance Official. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigation by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which had not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC facility stay. The facility will not prohibit or in any way discourage a resident from communicating with external entities including federal and state surveyors or other federal or state health department employees. Upon request, the facility will give a copy of this grievance policy to the resident. This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of a grievance. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. Take any immediate actions needed to prevent further potential violations of any resident rights. Forward the Grievance form to the Grievance Official as soon as possible. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. All staff involved in the grievance investigation should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgement of complaint/grievance and actively working toward a resolution of that complaint/grievance. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written investigation will include at a minimum: The date the grievance was received. The steps taken to investigate the grievance. A summary of the pertinent findings or conclusion regarding the resident's concern(s). A statement as to whether the grievance was confirmed or not confirmed. Any corrective action taken or to be taken by the facility as a result of the grievance. The date the written decision was issued. The facility will make prompt efforts to resolve grievances.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview, and record review, the facility failed to protect the residents' right to be treated with dignity and respect, to include the right to be free from physical restraints for 1 of 6 residents (Resident #1) reviewed for physical restraints. The facility failed to have medical symptoms for Resident #1 that warranted use of physical restraint; failed to have an order for use of Grab Bars on the bed; and failed to conduct on-going evaluation for use of restraint. Resident #1 sustained a fall on 06/22/24, left arm was caught between the mattress and the grab bar resulting in a left wrist fracture and contusion to right hip. This failure could place residents with restraints at risk of restricted movement, entrapment, decline in ADLs function, and psychological distress. The findings included: Review of the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to our hospital due to fall. Patient had an accidental mechanical fall 2 days ago from her bed, when she rolled from her bed. Her left hand was caught in the handrail and landed on her left lower limb. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Review of the Physician Progress Note dated 07/10/24 written by attending for Resident #1 revealed, Chief Complaint: s/p (status post) hospitalization secondary to fall and right hip contusion (a bruise caused by a direct blow or an impact, such as a fall.) and complain of LBP (low back pain) and review of X-rays. The patient was seen in LTC facility, as per nursing she had been complaining of LBP for last few days and she has been medicated with PRN Oxycodone. Oxycodone is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated.) Review of Quarterly MDS dated [DATE] for Resident #1, revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMs Score 06, (severely impaired), no behavior symptoms, wheelchair, ADLs-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Requires partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan Date initiated 02/09/24 and revised 02/10/21 for Resident #1 revealed, I have Cognitive Impairment r/t dementia, episodes of disorganized thinking, episodes of inattention, and Impaired Safety Awareness. Revised 06/26/24 Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: 02/03/22 Will keep closer to nurses' station for closer supervision. 08/25/23 Continue with bed to lowest position with floor mat next to bed. Instruct resident to call for help before getting out of bed or chair, always keep call light in reach. Provide toileting assistance per rounds and PRN. Date initiated 02/09/21; Revised 02/10/21 I require assist with ADLs transfers and toilet use. Approaches: Date initiated: 02/10/23; Revised 07/07/23. Bed Mobility: independent I use the quarter enablers to assist me in bed for reposition and transfers. Date initiated: 08/31/23. May use T-bar for bed positioning. Transfer, limited assistance x 1 person, uses quarter enablers to assist in support for transfers. Record review of Physician Order Summary Report dated 07/08/24 at 5:28 PM for Resident #1 revealed, Order Date Range: 04/01/24 - 07/31/24 did not document an order for use of grab bars. Record review of Resident #1's electronic record nurse's progress notes revealed did not have documentation of alternative approaches attempted prior to installing or using grab bars. The facility did not have a comprehensive assessment to determine the resident's needs, and whether or not the use of grab bars met those needs. The facility did not have documentation Resident #1 was assessed for risk of entrapment between mattress and grab bars. The facility did not have signed consent from the resident's responsible for use of the grab bars. Record review of Event Report dated 06/22/24 at 1:00 AM written by LVN B, for Resident #1 revealed, Incident Description Nursing Description: heard yelling from hall. Nurse entered room and observed her on the floor with left arm in the siderail. Resident Description: She doesn't know what she was doing. She thinks she was just turning over and slipped off the bed. Immediate Action Taken Description: Assessed for injuries. X 2 assist to bed. Assessed left arm and found 3 inch skin tear to forearm. Area cleansed with normal saline. Skin protectant applied. Edges approximated and secured with steri strips. Nonstick dressing and kerlix applied as secondary dressing. Neuro checks initiated. Injuries Observed at time of incident-No injuries observed at time of incident. Mental Status: Oriented to Person and Situation. Injuries Report Post Incident-No injuries observed post incident. Predisposing Situation Factors-Other, Side Rails up. Record review of the electronic Nurse Progress Note dated 06/22/24 at 1:44 AM, written by LVN I revealed, heard resident yelling from hallway. Nurse went to investigate. Found resident on resident on the sitting [sic] on the floor with her left arm in the enabler. With 2 assist, [sic] was removed from enabler. Assessment conducted. 2 assist [sic] to bed. Resident doesn't know what happened. She thinks she was just rolling over. She was soiled with BM. This nurse believes she may have been trying to go to the restroom. This nurse pulled up her sleeve and found a 3-inch skin tear to her left forearm. She had a Fall Risk band in place. Arm band removed. As it may have contributed to the skin tear. Area cleansed with NS (normal saline). Skin prep barrier. Edges approximated and secured with steri-strips (thin adhesive bandages used for skin closure). Secondary dressing applied, non-stick dressing and kerlix. Neuro checks initiated and WNL (within normal limits). Family member, MD and DON notified. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the SBAR INTERACT form dated 06/22/24 at 2:19 AM, for Resident #1 revealed, The Change of Condition: Fall. Primary Diagnosis is Urinary Tract Infection. Outcome of Physical Assessment: Mental Status Evaluation: No changes observed. Functional Status Evaluation: Fall. Skin Status Evaluation: Skin Tear. Pain Status Evaluation: was left blank. Record review of the Nurse Progress Note dated 06/22/24 at 7:59 AM, for Resident #1 written by RN L, revealed Per attending nurse pt. S/P fall resulting in a skin tear to left forearm. Area assessed and measured L 4 cm x W 1.5 cm, unable to assess depth. Noted skin tear with edges well approximated with steri-strips in place. Wound care performed as ordered. Pt. tolerated well. Record review of the Nurse Progress Note dated 06/23/24 at 1:00 PM written by LVN E, for Resident #1 revealed, resident had a fall on 6/22 prior to day shift. Ordered stat x-ray of lumbar spine, pelvis, bilateral hips, left forearm for pain related to fall. X-ray completed on 06/23/24 with abnormal results, acute and suspected fractures. Consulted with attending physician and family member. ADON notified. Resident to be transferred to hospital. Review of the Provider Investigation Report dated 06/23/24 for Resident #1, revealed incident date 06/22/24 at 1:00 AM in resident room. Incident Category: Other. If other specify: Bruise of unknown origin. Resident x-ray showed osteopenia. Description of allegation: Resident fell out of bed resulting in a skin tear to the left forearm. Assessment: 06/22/24 at 1:15 AM, by LVN I, documented resident received a skin tear to her left forearm as a result from the fall. Nurse provided treatment to left forearm for the skin tear. Investigation summary: Resident was assessed at the time of the fall and had complete range of motion. Later in the day the resident complained about having pain in her leg. Stat x-rays were ordered and they performed the x-rays on the 23rd of the lumbar spine, pelvis, both hips, and left forearm. The results of the x-ray were her left wrist had a fracture and her right hip had a fracture. Upon further tests at the hospital, it was determined that the right hip may or may not have a fracture. We are awaiting results from the MRI. The left [sic] was fractured and was treated with pain management. Provider Response: Provide all steps taken immediately to make sure resident(s) are protected including evaluating if resident feels safe, room relocation, increased supervision, immediate notification to physician and responsible party when involving an injury or change in condition, removal of alleged perpetrator and other measures to prevent further abuse, neglect, exploitation, and misappropriation. The resident returned to the facility and is receiving pain management for her fractured arm. Facility Investigation Findings: Inconclusive. Provider action taken Post-Investigation: Facility will continue to monitor the resident for any other adverse affects [sic]. In an interview on 07/08/24 at 8:43 AM, with LVN J, revealed Resident #1 was alert, oriented to person and place. Chairbound, propels her wheelchair with her feet independently. Transfer independently from bed to chair and chair to bed. Toilets independently. Uses call-light for assistance. Residents are checked every two hours by nurses and CNAs. LVN J reported CNAs stay at the decentralized stations to monitor residents and answer call-lights when they are doing their charting. LVN J reported that Resident #1 was impulsive and required close supervision and re-direction. Resident can verbalize needs. Resident's family member visits daily. Resident uses grab bars on side of bed to get in and out of bed and to turn & reposition. Resident sustained a fall on the weekend. After the fall, the grab bars were discontinued. Resident #1 was still able to get in and out of bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/08/24 at 4:58 PM, with LVN D revealed, Resident #1's family member visits daily on the evening shift. LVN D reported resident was alert, oriented to person, place, and recognized familiar people. Resident was able to verbalize needs and was able to make decisions. It was reported that the resident bangs on the wall with a cup for help. Resident can use her call light and does not know why the resident bangs on the wall for help. LVN reported resident frequently attempts to toilet without assistance. Resident was sent to the hospital 2 weeks ago on the night shift because she was found on the floor and sustained a skin tear to the left arm and a fractured left wrist. Resident had Grab Bars on her bed to turn & reposition, and to get in and out of bed on her own. After the incident she got a different bed, and the Grab Bars were removed. Resident #1 was still able to get in and out of bed on her own. She continues to require close supervision and re-direction, so she does not attempt to use the toilet without assistance. Interview and observation 07/09/24 at 6:09 AM, with LVN B on the 10-6 shift revealed she has been employed at the facility for two and a half years and Resident #1 had always had the grab bars on the side of the bed. It was observed that Resident #1 did not have grab bars on her bed. Resident was asleep, in a low bed and there was a floor mat next to the side of the bed. The bed was against the wall. LVN B stated, she was assigned to Resident #1 on the day of the incident on 06/22/24. LVN B demonstrated to the surveyor, that Resident #2 was found on the floor on the fall mat, her legs were bent at the knees, and her buttocks were on lower legs, on her calves like in a sitting position facing the bed and was holding the grab bar with her left hand, and her arm was stuck slightly above the elbow joint between the mattress and the grab bar. The plastic bracelet on her left arm was caught in the skin tear on the left arm. LVN B stated, that on that day, she was walking down the hall towards the decentralized nursing station, two doors from Resident #1's room and heard someone moaning and yelling out. When she went to check to see who was yelling. Upon entering Resident #1's room, she noted that her left arm was stuck between the mattress and the Grab Bar on the side of the bed. LVN B reported she had immediately went to get help to release the left arm that was stuck between the mattress and the grab bar. LVN B reported there was not a gap between the mattress or the Grab Bar. LVN B reported they slightly lifted the mattress to release the arm. LVN B stated Resident #1 had not complained of pain upon assessment and did not have guarded movement when she was put in bed, resident only had a superficial skin tear to the left arm, that she cleaned with normal saline and applied steri-strips. LVN B stated she had completed an Event Report and Interact SBAR Communication Form and notified physician, responsible party, and DON. LVN B reported an x-ray was done on the morning shift on that day. LVN B reported that prior to the incident, Resident #1 was able to get in and out of bed by using the Grab Bar on the sides of the bed, unsteady gait, confused at times, oriented to person, place, recognizes familiar people, and able to verbalize needs. The resident sleeps most of the night, occasionally gets out of bed and propels her wheelchair to the bathroom and attempts to toilet without assistance. LVN B reported resident required close supervision and re-direction to prevent falls. LVN B reported rounds were made every 2 hours by the nurses and CNAs. It was reported that resident was at Risk for falls prior to incident. LVN B reported resident occasionally used the call light or banged on the wall with her hand or the call light when she wants help to go to the bathroom. In an interview 07/09/24 at 11:22 AM with CNA A revealed, Resident #1 was alert, confused at times, able to verbalize needs, very impulsive, frequently gets in and out of bed by holding on the grab bars on the side of the bed and uses the grab bars to turn & reposition in bed. Resident also frequently attempts to toilet without assistance. Resident requires close supervision and re-direction. They encourage the resident to go to the toilet when they go to her room during scheduled rounds. She does not call for help. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/09/24 at 3:28 PM, revealed the family member was visiting resident. The family member reported that Resident #1 had fallen from the bed, sustained a big skin tear on her left arm, fractured her arm and hip. After the fall, they changed her bed and removed the grab bars on side of the bed. The family member stated, Now, the resident is no longer able to get out of bed on her own or turn & re-position while in bed since they removed the grab bars on the side of the bed. The family member reported Resident did not feel safe without the Grab Bar on the side of the bed and was afraid of falling when she got out of bed. The resident was sent to the emergency room , and they kept her over-night. The x-ray and CT scan revealed a hip fracture. In the hospital they did an MRI and the doctor reported that there was no right hip fracture and that she had a large contusion (is a bruise caused by a direct blow to the body that cause damage to the surface of the skin and to deeper tissues as well depending on the severity of the blow) on her hip. Interview and record review on 07/10/24 at 1:05 PM with the DON revealed, Resident #1's bed was changed to a high/low bed and that was not as wide as the bed that she had when she sustained the fall on 06/22/2024. The DON reported the day of the incident on 06/22/24, Resident #1 was found by LVN I the night nurse on the floor, by the side of the bed with one of her arm's caught between the mattress and the grab bar that was attached to the side of the bed. The Resident sustained a skin tear to the left forearm. The DON reported that the resident had not complained of pain at the time of the initial assessment that was completed by the night nurse. Later in the day, Resident #1 complained of having pain to her right leg and x-rays were ordered. The X-Rays revealed Resident had a fracture to the left wrist and right hip. Resident was sent to the hospital for evaluation and was admitted . The hospital reported MRI revealed Resident did not have a hip fracture and had a contusion to the right hip. Resident returned to the facility on [DATE] with a diagnosis of left wrist fracture and contusion to right hip. The DON reported facility had a meeting with the Resident's family member and the Ombudsman when the decision was made to remove the Grab Bars on the side of the bed and the resident's family member had agreed with the recommendation to remove the Grab Bars. The DON stated, We did not document this meeting in the resident's electronic clinical record, we should have. I do not remember the date of the meeting. The DON stated, I did not find a physician's order listed in the Physician Order Summary Report dated July 08, 2024, Order Date Range: 04/01/24 - 07/31/24 to use Grab bars on the side of the bed as an enabler. The DON stated, We needed to have a physician's order to use the Grab Bars on the side of the bed as an enabler, according to facility's policy on use of bed rails. We do not have a signed consent from the responsible party for Resident #2 to use Grab Bars on the side of the bed. The DON did not know how long Resident #1 had the grab bars on her bed. The DON stated that she was not aware of what was documented on the facility's policy on used of restraints and need to read the policy and procedure. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 07/11/24 at 10:16 AM, with CNA K reported she was on duty on 06/22/24 when Resident #1 had sustained a fall form the bed. CNA K reported Resident #1 had the tendency to get out of bed without assistance during the night shift. CNA K reported was charting, at the decentralized nurse's station when she heard someone was yelling for help. CNA K reported LVN B was coming down the hall towards the decentralize nurse's station, and she went to check the rooms to see who was yelling. When LVN B entered Resident #1's room, she came out right away and asked me to go to the room to help her because Resident # 1 was stuck between the mattress and the grab bar. CNA K stated that upon entering the room, she noted Resident #1 was on the floor and her knees and her buttocks were resting on her calves, the resident was facing towards the bed and the left arm was caught between the Grab Bar and the mattress. CNA K she had slightly lifted the mattress to remove the left arm from between the mattress and the Grab Bar and noted resident had a big skin tear to the lower left arm. Aide reported that there was no gap between the mattress and the Grab Bar. CNA K reported that the Fall Risk bracelet on the left arm had sliced the skin to the arm, where the bracelet got stuck between the mattress and grab bar. CNA K reported they had put the resident back to bed and was not fully awake. The resident kept saying for her saying a family had fallen with her and wanted to know where he was. CNA K reported Resident #1 sleeps most of the night, and occasionally got out of bed without assistance to use the toilet. It was reported that Resident #1 requires close supervision and re-direction, because she has a history of falls. CNA K reported Resident #1 has had the Grab Bars on her bed, since she started working at the facility 7 months ago. Review of facility's policy & procedure on Proper Use of Bed Rails implemented 07/2022 revealed, Topic: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. Bed Rails are adjustable or rigid plastic bars that attach to the bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Removes easily means that the manual methods, physical or mechanical device, equipment, or material, can be removed intentionally by the resident in the same manner as it was applied by the staff. Resident Assessment: As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether the use of bed rails meet those needs: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, sleep habits, ability to toilet self safely, cognition, communication, mobility (in and out of bed), risk for falling. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). Barriers to resident from safely getting out of bed. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rails or in the bed rail itself. Informed consent from the resident or resident's representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. The information that the facility should provide to the resident, or resident representative includes, but is not limited to: The resident benefits from the use of the bed rail, risk from the use of bed rails, alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were inappropriate. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Ongoing Monitoring and Supervision. On-going assessment to assure that the bed rail is used to meet the resident's needs.

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Cimarron Park Nursing and Rehabilitation Center	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	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 20026 Based on interview and record review, the facility failed to implement written policies that prohibit and prevent abuse for 1 of 12 employees (the Administrator) reviewed for criminal background checks. The facility failed to run the Administrator's criminal background check prior to him starting his duties on 05/13/24. This failure could place residents at risk of potential abuse. Findings included: Interview and record review on 07/12/24 at 5:08 PM with the Administrator revealed his start date was 05/13/24. The Administrator informed surveyor facility did not have any documentation in his personal file that Criminal Check, Employee Misconduct Check and Nurse Aide Registry Check had been completed prior employment or on this first day of work. The Administrator reported that he had terminated the HR manager on 07/11/24 and would send him a text message to see if he would respond back to check if he had completed his criminal check prior to and/or on first day of employment. The Administrator stated, I have checked my personnel file several times and the HR Manager's office and did not find any of these documents. The Administrator stated, Criminal Checks needed to be completed according to facility policy. Review of the facility's Policy & Procedure dated 07/20/22 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, exploitation, and misappropriation of resident property. The components of the facility abuse prohibition plan are discussed herein: Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' check shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency, or academic institution. 3. The facility will maintain documentation of proof that the screening occurred.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #1, and Resident #3) of 6 residents reviewed for accuracy of MDS assessments. - The facility failed to ensure that Resident #1's MDS accurately reflected resident had an Enteral Feeding. -The facility failed to ensure that Resident's #3's MDS accurately reflected resident had an infection to right knee. 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 Record review of the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Record review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension. Record review of the Quarterly MDS dated [DATE] for Resident #1 completed by Director of Reimbursement revealed MDS did not document resident had a Feeding tube. Record review of the Care Plan revised 02/10/21 for Resident #1 revealed, Enteral Feeding: Peg Tube r/t aphasia [sic]. Aphasia (a language disorder that makes it hard for a to read, write, and say what you mean to say.) Review of the Medication Administration Record dated May 2024 for Resident #1 revealed, Order Date Range: 04/01/24 - 07/31/24. Order date: 04/18/24 Diabetic Source 1.2 at 45 ml/hr. with water flush 120 m/4 hr. Observation on 07/08/24 at 4:50 PM, revealed Resident #1 was propelling her wheelchair in her room with her hands and feet towards the bathroom and was attempting to open the bathroom door. The Enteral Feeding pump was attached to the back of the wheelchair. Interview on 07/09/24 at 3:01 PM with the DON, revealed the two MDS nurses had quit at the same time, and they had just hired two new MDS nurses that were in training due to not having experience with completing MDS forms. The DON confirmed that Quarterly MDS assessment completed on 05/21/24 by Director of Reimbursement did not document Resident # 2 had Enteral Feeding, had a history of falls since admission to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 Closed Record review of the Admission Record dated 07/09/24 for Resident #3 revealed, original admitted : 06/06/24. Resident discharged home on 07/08/24 with Home Health Services. Review of the Initial Medical Visit dated 06/10/24 for Resident #3 revealed, [AGE] year-old-female discharge form hospital where she was treated for right knee septic arthritis (is a painful infection in a joint that can come from germs that travel through your bloodstream from another part of your body) for which patient underwent a Right knee irrigation and debridement (a process of removing dead skin and foreign material from a wound) on 05/25/24. The patient continues with Vancomycin 1000 mg/200 ml BID and Ceftriaxone 2 GM QD (daily) through PICC line (a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near your heart) to RUE (Right Upper Extremity). Active Medical Problems: Hypertension, Diabetes Mellitus type 2, Right knee irrigation and debridement on 05/25/24, Right knee arthroplasty (a surgery to restore the function of a joint) 06/20/23. Review of the Medical Visit dated 06/12/24 for Resident #3 underwent right knee arthrotomy (is a surgical exploration of a joint) with debridement and synovectomy with poly insert exchange (surgical removal of the membrane that lines a joint). Patient also seen by ID (Infectious disease doctor) recommending continue IV antibiotic for 6 weeks. Patient was admitted to our facility for PT and rehab. Review of the Admission MDS dated [DATE] for Resident #3, completed by Director of Reimbursement revealed clear speech, makes self-understood, understands others, vision adequate, BIMs Score 15 (Cognitively Intact), wheelchair, occasionally incontinent of bowel & bladder; other major orthopedic surgery; surgical wounds; antibiotic; IV medications. MDS did not document resident had an infection to right knee. Review of the Care Plan revised on 07/09/24 for Resident #3, revealed Resident was on IV (giving medicines or fluids through a needle or tube inserted into a vein) medications. Revised 07/09/24 Resident was on antibiotic therapy. Interventions: Administer ANTIBIOTIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Report pertinent lab results to MD. Review of Physician Order Summary Report dated 07/09/24 at 3:08 PM, Order Date Range: 05/01/24 - 07/31/24 for Resident #3 revealed, Order Date: 06/06/24 Ceftriaxone Sodium (antibiotic to treat bacterial infections) 2 GM intravenous one time a day for infection to surgical site. Order Date: 06/06/24 Vancomycin HCl (antibiotic to treat bacterial infections) intravenous solution 1000 mg/200 ml every 12 hours for infection to surgical wound. In an interview on 07/09/23 at 3:59 PM, LVN F, revealed Resident #3 was at the facility for a very short stay and was discharged back home. Resident was alert and oriented to x 4, was admitted for IV anti-biotics, status post-surgery to right knee, hardware got infected. Review of the facility's policy & procedure on Maintaining Minimum Data Set (MDS) Assessments implemented 07/2022 revealed, policy did not relate to accuracy of MDS assessments. No other policy was brought forth prior to exit.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interviews and record reviews the facility failed to coordinate with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability, or related conditions received care and services to meet the needs of the residents for 2 (Resident #4 and Resident #6) 2 residents reviewed for PASRR services. -The facility failed to provide Specialized Services to Resident #4 as agreed to during the interdisciplinary meeting. -The facility failed to ensure that all PSCR benefits were being provided to Resident #6. The failures could affect residents who are PASRR positive by placing them at risk of not receiving needed PASRR services which could lead to a decline in health and well-being. Findings included: Resident #4 Review of the Admission Record dated 07/09/24 for Resident #4 revealed original admitted [DATE]; re-admitted [DATE]. Review of a Medical Visit dated 01/02/24 for Resident #4 revealed, [AGE] year-old-female status post fracture right ankle, s/p closed reduction (is a procedure to set (reduce) a broken bone without cutting the skin open), transferred to facility to resume her rehabilitation. Past Medical History: schizophrenia, bipolar disorder, depressive disorder, anxiety disorder, hypertensive heart disease, GERD. Review of the Quarterly MDS dated [DATE] for Resident #4 revealed, hearing adequate, clear speech, made self-understood, understood others, vision impaired, BIMs score 15 (cognitively intact), no behaviors, used a wheelchair, frequently incontinent of bowel & bladder, received an antipsychotic and antidepressant. Resident received Occupational Therapy and Physical Therapy. Review of Resident #4's Care Plan revised on 01/11/24 revealed, Resident #4 had been identified as having PASRR positive status R/T (related to) intellectual/development disability. Interventions included: Invite the LIDDA representative and responsible party to the quarterly care plan meeting to discuss my function status. Level PASRR completed. Review of the Care Plan revised on 01/11/24 for Resident #4 revealed, Resident #4 had been identified as having PASRR positive status R/T a severe mental illness: bipolar, schizophrenia, major depression. Interventions included: Coordinate services with a representative from the LMHA. Invite the LMHA representative and responsible party to the quarterly care plan meeting to discuss Resident #4's status. Participation may be in person or telephonic. Level 2 PASRR completed. Notify MD (physician) and RP (responsible party) as needed. Psych consult as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan revised on 01/11/24 for Resident #4 revealed, required assistance with ADL (activities of daily living) and at risk of deterioration in ADLs r/t (related to) immobility, physical impairment, Self-Care performance fluctuates d/t (due to) pain. Review of the Care Plan revised on 01/11/24 for Resident #4 revealed, she had depression/Bipolar and was at risk for fluctuation in moods, little interest, or pleasure in doing things, and decreased socialization. Currently receiving: Venlafaxine 75 mg 1 tablet by mouth daily. Review of the Care Plan revised on 01/11/24 for Resident #4 revealed, had the potential for hallucinations, delusions, and behaviors r/t schizophrenia/psychosis/mental illness. Currently receives antipsychotic medication. Review of the PASRR Level 1 Screening dated 12/28/23 for Resident #4 revealed, PASRR Screening: Mental Illness-Yes. Review of the PASRR Evaluation dated 01/12/2024 for Resident #4 revealed, Type of Evaluation IDD and MI. Date of IDD Evaluation: 01/12/24 by Habilitation Coordinator. Section: B0100 Does the individual has a Developmental Disability which manifested before the age of 18? Yes. -Specialized Services Determination/Recommendations: Yes; Self-monitoring and coordinating medical treatment. Yes -Self-help with ADLs such as toileting, grooming, dressing, and eating. Yes -Sensorimotor development with ambulation, positioning, transferring, or hand eye coordination to the extent that a prosthetic, orthotic, corrective or mechanical support device could improve independent functioning. Yes -Social development to include social/recreational activities or relationships with others. Yes -Expressing interest, emotions, making judgement, or making independent decisions. Yes -Independent living skills such as cleaning, shopping in the community, money management, laundry, accessibility within the community. Yes -Vocational development, including current vocational skills. Yes -Additional adaptive medical equipment or adaptive aids to improve independent functioning. Yes Section C: Primary Diagnosis of Dementia - No. Mental Illness: Schizophrenia, Mood Disorder, Panic or Other Severe Anxiety Disorder. Functional Limitations: None. Oriented to person, place, and time. Section E: 1 fall in the last 90 days. Poor balance & weakness. Clear speech understood and understood. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PASRR Comprehensive Service Plan (PCSP) Form for Resident #4 revealed, Quarterly Meeting on 04/25/24. The form reflected Resident #4 was PASRR positive for IDD only. Nursing Facility Specialized Services reflected: Customized Manual Wheelchair (6) Pending. New-PT/OT. Review of the NFSS (Nursing Facility Specialized Services) for Resident #4 revealed, Status: Form Not Accepted. The following errors were returned from TMHP: (Fatal) The Occupational Therapy (OT) request cannot be processed because the person does not have a Medicaid Daily Care or Medicare Skilled Nursing service authorization for the submitted Provider number as of the assessment date. Correct the OT assessment date or submit the necessary paperwork to establish the appropriate service authorization before resubmitting the NFSS form. Habilitative Therapies Type: Occupational Therapy and Physical Therapy. Review of the Occupational Therapy Evaluation & Plan of Treatment for Resident #4 revealed Certification Period: 05/15/24 - 07/13/24. Start of Care: 05/15/24. Diagnoses: Displaced trimalleolar fracture of right lower leg (happens when you break your lower leg sections that form your ankle and help you move your foot and ankle), subsequent encounter for close fracture with routine healing. Encounter for other orthopedic aftercare, Muscle Weakness, Unsteadiness on feet, Other reduced mobility. Plan of Treatment: Treatment Approaches May Include Therapeutic exercises, Neuromuscular reeducation, Manual therapy techniques, Group therapeutic procedure, Occupational therapy evaluation: high complexity, Therapeutic activities, Self-care management training. Frequency: 3 time(s)/week. Duration: 60 days. Intensity: Daily. Cert. Period: 05/15/24 - 07/13/24. Payer: PASRR (MCD) Start of Care: 05/15/24. Review of the Physical Therapy Evaluation & Plan of Treatment for Resident #4 revealed Certification Period: 05/15/24 - 07/13/24. Start of Care: 05/15/24. Diagnoses: Displaced trimalleolar fracture of right lower leg, subsequent encounter for close fracture with routine healing. Encounter for other orthopedic aftercare, Muscle Weakness, Unsteadiness on feet, Other reduced mobility. Plan of Treatment: Treatment Approaches May Include Therapeutic exercises, Neuromuscular reeducation, Gait training therapy, Manual therapy techniques, Physical therapy evaluation, Therapeutic exercises, Wheelchair management training. Frequency: 3 time(s)/week. Duration: 60 days. Intensity: Daily. Cert. Period: 05/15/24 - 07/13/24. Focus POT: Skilled Intervention Focus = Restoration. Interview on 07/09/24 at 3:01 PM, with Resident #4 revealed, she was alert, oriented to person, place and time. Resident reported she was getting physical and occupational therapy every day. Interview on 0712/24 at 4:30 PM with ADON, in the presence of Corporate Consultant revealed, corporate staff were responsible for making the arrangements to provide Specialized Services for a PASRR positive resident as agreed to during the resident's interdisciplinary team (IDT) meeting. It was reported that the DON, was responsible for checking the LTCSP portal to ensure NFSS (Nursing Facility Specialized Services) forms were transmitted timely. Corporate Consultant reported that Resident #4 initially did not have Medicaid upon admission and the facility had paid for the resident's therapy. Resident #6 Review of the Admission Record dated 07/09/24 for Resident #6 revealed original admitted [DATE]. Review of a Medical Visit dated 01/20/24 for Resident #6 revealed, Initial Visit, [AGE] year-old-female treated for dementia, down syndrome, osteoarthritis. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly MDS dated [DATE] for Resident #6 revealed, hearing adequate, clear speech, usually makes self-understood, usually understands others, vision adequate, BIMs score 07 (cognitive ability severely impaired), used a wheelchair, ADL's set up assistance with meals, partial/moderate assistance with oral hygiene, toileting, hygiene, shower, lower body dressing, and personal hygiene; partial/moderate assistance with sit to lying, sit to stand, chair/bed-to-chair transfer, and toilet transfer; incontinent of bowel & bladder; Medication: getting an antidepressant and was receiving occupational therapy, and physical therapy. Review of the Care Plan dated 06/24/24 for Resident #6 revealed: -Care Plan revised 02/28/24, revealed Resident was at Risk for falls r/t (related to) gait problems and impaired cognition. -Care Plan revised 02/28/24, revealed Resident required assist with ADLs (activities of daily living) r/t cognitive impairment, physical impairment. -Care Plan revised 02/22/24, revealed Resident was identified as needing the specialized recommended services of customize manual wheelchair. The customize manual wheelchair was purchased for me as my own equipment. -Care Plan revised 02/22/24, revealed Resident had been identified as having PASRR positive status r/t intellectual/developmental disability. Interventions: Level PASRR completed. Report any need to evaluate for habilitative services and/or durable medical equipment to maintain my current level of function. Staff to utilize all community resources available for resident. -Care Plan revised 02/22/24, revealed Resident required specialized services of (PT/OT/ST) to maintain her highest level of practicable wellbeing. Review of the PASRR Level 1 Screening dated 01/16/23 for Resident #6 revealed, Intellectual Disability - Yes. Review of PASRR Evaluation dated 01/20/23 for Resident #6 revealed, type of assessment IDD only. Section: B0100 Does the individual has a Developmental Disability which manifested before the age of 18? Yes. B0200 To your knowledge, does the individual have a Developmental Disability other than an Intellectual Disability that manifested before the age of 22? Yes. B0400. Does the individual need assistance in any of the following areas? -Self-monitoring of nutritional support. Yes. -Self-monitoring and coordinating medical treatment. Yes. -Self-help with ADLs such as toileting, grooming, dressing, and eating. Yes -Expressing interest, emotions, making judgement, or making independent decisions. Yes -Independent living skills such as cleaning, shopping in the community, money management, laundry, accessibility within the community. Yes (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B0500 Recommended Services: Habilitation Coordination and Independent Living Skills Training. B0600 Recommended Services Provided/Coordinated by Nursing Facility Specialized Occupational Services. Review of PASRR Comprehensive Service Plan (PCSP) Form for Resident #6 revealed, Quarterly Meeting on 05/01/24. Medical Eligibility confirmed. PASRR positive for IDD only. Nursing Facility Specialized Services: Customized Manual Wheelchair (8) completed; Specialized Assessment OT/PT/ST not needed; Specialized Therapy OT/PT. Specialized Habilitation Coordination. Review of Occupational Therapy Evaluation & Plan of Treatment for Resident #6 revealed, Certification Period: 04/08/24 - 06/06/24. Start of Care: 04/08/24. Payer: PASRR (MCD). Diagnose: Unspecified Dementia, Other symptoms and signs involving the musculoskeletal system, Down Syndrome, Muscle weakness generalized, Unsteadiness on feet, Other reduced mobility. Plan of Treatment: Therapeutic exercises, Neuromuscular reeducation, Manual therapy techniques, Group therapeutic procedure, Occupational therapy evaluation: high complexity, Therapeutic activities, Self-care management training. Frequency: 3 time(s)/week. Duration: 60 days. Intensity: Daily. Cert. Period: 04/08/24 - 06/06/24. Skilled Intervention Focus = Restoration. Payer: PASRR (MCD) Start of Care: 04/08/24. Review of Occupational Therapy Evaluation & Plan of Treatment for Resident #6 revealed, Certification Period: 05/15/24 - 07/31/24. Start of Care: 05/15/24. Payer: PASRR (MCD). Diagnose: Unspecified Dementia, Other symptoms and signs involving the musculoskeletal system, Down Syndrome, Muscle weakness generalized, Unsteadiness on feet, Other reduced mobility. Plan of Treatment: Therapeutic exercises, Neuromuscular reeducation, Manual therapy techniques, Group therapeutic procedure, Occupational therapy evaluation: high complexity, Therapeutic activities, Self-care management training. Frequency: 3 time(s)/week. Duration: 60 days. Intensity: Daily. Cert. Period: 05/15/24 - 07/13/24 Skilled Intervention Focus = Restoration. Payer: PASRR (MCD) Start of Care: 05/15/24. Review of Physical Therapy Evaluation & Plan of Treatment for Resident #6 revealed, Certification Period: 04/08/24 - 06/06/24. Start of Care: 04/08/24. Diagnose: Unspecified Dementia, Other symptoms and signs involving the musculoskeletal system, Down Syndrome, Muscle wasting and atrophy, not elsewhere classified, multiple sites. Difficulty walking not elsewhere classified Skilled Intervention Focus = Restoration. Review of Physical Therapy Evaluation & Plan of Treatment for Resident #6 revealed, Certification Period: 05/15/24 - 07/13/24. Start of Care: 05/15/24. Diagnose: Unspecified Dementia, Other symptoms and signs involving the musculoskeletal system, Down Syndrome, Muscle wasting and atrophy, not elsewhere classified. multiple sites. Difficulty walking not elsewhere classified. Skilled Intervention Focus = Restoration. Interview with the ADON at 4:30 PM, in the presence of the Corporate Consultant revealed that Resident #6 initially was not eligible for Medicaid and the facility had paid for Resident #6's Physical and Occupational Therapy. The ADON reported that Resident #6 now had Medicaid services and was currently getting Occupational and Physical therapy services that were paid by PASRR (MCD). The Surveyor requested policy and procedure on PASRR and Coordination of Specialized Services. No policy was provided prior to exit.

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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 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 1 of 6 residents (Resident #1) reviewed for comprehensive care plans in that: The facility failed to develop a comprehensive care plan for Resident #1 after she sustained a fall on 06/22/24 that addressed the resident's skin tear and fracture to her left wrist. 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 the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #2 was initially admitted on [DATE] and readmitted [DATE]. Review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to the hospital due to fall. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Hence, after discussion with her PCP, plan was to prescribe pain medication for her pain, but facility's pharmacy was not opened at the time and hence was transferred to the hospital for pain management. Patient was still able to perform her ADLs by herself, but with pain. Baseline: She was wheelchair bound, able to transfer from bed to the chair and commode herself. She was still able to do so after the fall. Medical History: Acute UTI, Anxiety, Dementia, Lower back pain, osteoporosis, PVD (peripheral vascular disease is the reduced circulation of blood to a body part other than the brain or heart). Review of the Hospital Physician Progress note dated 06/24/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. Reason for Consultation: Possible right hip intertrochanteric femur fracture (a specific type of hip fracture) and possible left distal radius fracture (the larger forearm bone is broken near the wrist). Will recommend an MRI (type of diagnostic test that can create detailed images of nearly every structure and organ inside the body). Splint to left wrist. (continued on next page)

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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 Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed hearing adequate, clear speech, usually understood, usually understood others, vision impaired, BIMs Score 06, (severely impaired cognition), no behavior symptoms, used a wheelchair, ADL's-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Required partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel. Review of the Care Plan revised 02/10/21 revealed Cognitive Impairment-short term memory r/t dementia. Revised 06/26/24 Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: 12/12/23 Instruct resident to call for help before getting out of bed or chair. Always keep call light in reach, visible to resident and the resident is informed of its location and use. Review of the SBAR Communication Form dated 06/22/24 at 1:30 AM for Resident #1 completed by LVN B revealed, the change in condition: Fall. Skin Evaluation: Skin Tear. Review of the Nurse Progress Note dated 06/22/24 at 7:59 AM, written by RN L, revealed per the attending nurse pt. s/p fall resulting in a skin tear to left forearm. The area was assessed and measured L 4 cm x W 1. 5 cm, unable to assess depth. Noted skin tear with edges well approximated with steri-strips in place. Wound care performed as ordered. Pt. tolerated well. Review of the Nurse Progress Note dated 06/23/24 at 1:00 PM written by LVN E, for Resident #1 revealed, the resident had a fall on 06/22/24 prior to day shift. Ordered a stat x-ray of lumbar spine, pelvis, bilateral (both) hips, left forearm for pain related to fall. X-ray completed on 06/23/24 with abnormal results, acute and suspected fractures. Consulted with attending physician and family member. The ADON was notified. Resident #2 to be transferred to hospital. Record Review of Physician Order Summary Report dated 07/08/24 revealed, Order Date Range: 04/01/24 - 07/31/24. Order date: 06/22/24 X-ray to lower back, hips, pelvis, and left arm. Order date: 06/22/24 cleanse skin tear on left forearm with normal saline, pat dry, and apply steri-strips, apply dressing and secure with tape daily until healed. Interview and record review 07/10/24 at 1:05 PM with the DON revealed, Resident #1 had sustained a skin tear to the left forearm and fracture to her left wrist on 06/22/24 status post fall. The DON confirmed that the Care Plan did not address the resident had a skin tear to left arm that were sustained on 06/22/24 on the day of the incident. In an interview and record review 07/12/24 at 2:59 PM, with LVN MDS Nurse M in the presence of the ADON, revealed she had not care planned the skin tear to the left arm and fractured left wrist Resident #1 sustained on 06/22/24 after a fall. The MDS nurse stated she was new and was training on MDS assessments and care plans. The MDS confirmed these changes should have been care plan but had not had the time to do it. (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 facility's policy & procedure on Comprehensive Care Plans implemented 07/2022 revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents. The facility failed to place Resident #1's bed low to the ground and place the fall mat next to the bed while Resident #1 was in bed. This led to Resident #1 on 06/22/24 having her left arm/hand caught in between the grab bars (enablers) and the mattress, her right back shoulder hit the tray table, her right arm hit the trash can, and her rear hit the ground while her legs slid underneath the bed. An Immediate Jeopardy (IJ) was identified on 07/26/24 at 4:24 PM. While the IJ was removed on 07/27/24, the facility remained out of compliance at a scope of no actual harm and a severity level of isolated because the facility was continuing to monitor its plan of removal for effectiveness. This failure could place residents who are at risk for falls, injury, or death. The findings included: Record review of Resident #1's Admission Record dated 07/08/24 revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Record review of Resident #1's Hospital History & Physical dated 06/23/24 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to our hospital due to fall. Patient had an accidental mechanical fall 2 days ago from her bed, when she rolled from her bed. Her left hand was caught in the handrail and landed on her left lower limb. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Record review of Resident #1's hospital MRI dated 06/23/24, revealed, it was reported that the x-ray along with the CT scan and MRI, did not see any evidnce of a fracture on the MRI. There was questionable concern of CT scan of an area of the lesser trochanter that was fractuered. However she does have a chronic great trochanter fracture along with bruising. There was no evidnce of fracture here. Record review of Resident #1's Physician Progress Note dated 07/10/24 written by attending for Resident #1 revealed, Chief Complaint: s/p hospitalization secondary to fall and right hip contusion (a bruise caused by a direct blow or an impact, such as a fall.) and complain of LBP and review of X-rays. The patient was seen in LTC facility, as per nursing she had been complaining of LBP for last few days and she has been medicated with PRN Oxycodone. (Oxycodone is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMS Score 06, (severely cognitively impaired), no behavior symptoms, wheelchair, ADLs-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Requires partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel; No falls since admission. Record review of Resident #1's Physical Therapy Evaluation and Plan of Treatment dated 04/08/24, revealed, Resident #1 was supervision with transfers prior but was now a high fall risk due to trying to transfer without adequate strength. : Gross Motor Coordination = Impaired. Clinical Impressions: [AGE] year-old female who has decreased strength, coordination, and balance. Instructed patient and primary caregivers in safety sequencing techniques, safe bed mobility/transfers techniques, safety precautions and compensatory strategies to increase safety Record review of Resident #1's Fall assessment dated [DATE], revealed, intermittent confusion, 1-2 falls in the past 3 months, with a High-Risk Score of 13.0. Record review of Resident #1's Fall assessment dated [DATE], revealed, intermittent confusion, 1-2 falls in the past 3 months, with a High-Risk Score of 13.0. Record review of Resident #1's Enabler assessment dated [DATE] revealed, that it was incomplete. Commented that Resident #1's, level of consciousness or cognitive deficit was yes and stated forgetful/confused at times. Was there a risk to the resident if enablers are used? - Was left blank. There was no signature of Resident, guardian, or Legal Representative. Record review of Resident #1's Enabler assessment dated [DATE], revealed, that it was incomplete. The digital form was not signed nor was there any input in the questions such as, Was there a risk to the resident if enablers are used? (all left blank). Record review of Resident #1's Care Plan revised 02/10/21 revealed Cognitive Impairment-short term memory r/t dementia. Revised 06/26/24 Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: 08/25/23 Continue with bed to lowest position with floor mat next to bed. 06/22/24 Actual Fall. Interventions: Sent to emergency room . Ordered x-rays. 2/25/24 Bed will continue to be kept to lowest position while pt. is on bed to prevent further falls. 02/10/21 Fall mat next to bed. 12/12/23 Instruct resident to call for help before getting out of bed or chair. Always keep call light in reach, visible to resident and the resident is informed of its location and use. Revised 02/10/21 Require one person assistance with ADLs r/t cognitive deficit. Revised: 07/07/23 May use enablers x 2 to assist with turning & repositioning and enhance independence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Physician Order Recap reviewed on 07/24/24, revealed, there were no orders for fall mat nor lowering of bed. Record review of Resident #1's Physician Order Summary Report dated 07/08/24 at 5:28 PM revealed, Order Date Range: 04/01/24 - 07/31/24 Physician Order Summary did not document an order for use of grab bars. Record review of Resident #1's Event Report dated 06/22/24 at 1:00 AM written by LVN I revealed, Incident Description Nursing Description: heard yelling from hall. Nurse entered room and observed her on the floor with left arm in[sic] the siderail. Resident Description: She doesn't know what she was doing. She thinks she was just turning over and slipped off the bed. Immediate Action Taken Description: Assessed for injuries. X2 [sic] assist to bed. Assessed left arm and found 3-inch skin tear to forearm. Area cleansed with normal saline. Skin protectant applied. Edges approximated and secured with steri-strips. Nonstick dressing and kerlix applied as secondary dressing. Neuro checks initiated. Predisposing Situation Factors-Other, Side Rails up. Record review of Resident #1's electronic Nurse Progress Note dated 06/22/24 at 1:44 AM, written by LVN I revealed, heard resident yelling from hallway. Nurse went to investigate. Found resident on resident on the sitting [sic] on the floor with her left arm in the enabler. With 2 assist, [sic] was removed from enabler. Assessment conducted. 2 assist [sic] to bed. Resident doesn't know what happened. She thinks she was just rolling over. She was soiled with BM. This nurse believes she may have been trying to go to the restroom. This nurse pulled up her sleeve and found a 3-inch skin tear to her left forearm. She had a Fall Risk band in place. Arm band removed. As it may have contributed to the skin tear. Area cleansed with NS. Skin prep barrier. Edges approximated and secured with steri-strips (thin adhesive bandages used for skin closure). Secondary dressing applied, non-stick dressing and kerlix. Neuro checks initiated and WNL (within normal limits). [family member], MD and DON notified. Record review of Resident #1's SBAR INTERACT form dated 06/22/24 at 1:30 AM for Resident #1 written by LVN I revealed, The Change of Condition: Fall. Since this started it has gotten: Stayed the same. Primary Diagnoses is Urinary Tract Infection, dementia, diabetes mellitus. Outcome of Physical Assessment: Mental Status Evaluation: No changes observed. Functional Status Evaluation: Fall (one or more). Skin Status Evaluation: Skin Tear. Record review of Resident #1's Nurse Progress Note dated 06/22/24 at 7:59 AM, written by RN L, revealed Per attending nurse pt. s/p fall resulting in a skin tear to left forearm. Area assessed and measured L 4 cm x W 1.5 cm, unable to assess depth. Noted skin tear with edges well approximated with steri-strips in place. Wound care performed as ordered. Pt. tolerated well. Record review of the Nurse Progress Note dated 06/23/24 at 1:00 PM written by LVN E, for Resident #1 revealed, resident had a fall on 6/22 prior to day shift. Ordered stat x-ray of lumbar spine, pelvis, bilateral hips, left forearm for pain related to fall. X-ray completed on 06/23/24 with abnormal results, acute and suspected fractures. Consulted with attending physician and [family member]. ADON notified. Resident to be transferred to hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Provider Investigation Report dated 06/23/24 revealed incident date 06/22/24 at 1:00 AM in resident room. Incident Category: Other. If other specify: Bruise of unknown origin. Resident x-ray showed osteopenia (loss of bone density). Description of allegation: Resident fell out of bed resulting in a skin tear to the left forearm. Assessment: 06/22/24 at 1:15 AM, by LVN I, documented resident received a skin tear to her left forearm as a result from the fall. Nurse provided treatment to left forearm for the skin tear. Investigation summary: Resident was assessed at the time of the fall and had complete range of motion. Later in the day the resident complained about having pain in her leg. Stat x-ray were ordered and they performed the x-rays on the 23rd of the lumbar spine, pelvis, both hips, and left forearm. The results of the x-ray were her left wrist had a fracture and her right hip had a fracture. Upon further tests at the hospital, it was determined that the right hip may or may not have a fracture. We are awaiting results from the MRI. The left [sic] was fractured and was treated with pain management. Provider Response: Provide all steps taken immediately to make sure resident(s) are protected including evaluating if resident feels safe, room relocation, increased supervision, immediate notification to physician and responsible party when involving an injury or change in condition, removal of alleged perpetrator and other measures to prevent further abuse, neglect, exploitation, and misappropriation. The resident returned to the facility and is receiving pain management for her fractured arm. Facility Investigation Findings: Inconclusive. Provider action taken Post-Investigation: Facility will continue to monitor the resident for any other adverse effects [sic]. During an interview on 07/08/24 at 8:43 AM, with LVN J, revealed, stated Resident #1 was alert, oriented to person and place. Resident #1 was chairbound and propels her wheelchair with her feet independently. Resident #1 transfers independently from bed to chair and chair to bed. Resident #1 toilets independently and uses call-light for assistance. Residents are checked every two hours by nurses and CNAs. LVN J reported CNAs stay at the decentralized stations to monitor residents and answer call-lights when they are doing their charting. LVN J reported that Resident #1 was impulsive and requires close supervision and re-direction. Resident #1 can verbalize needs. Resident #1's family member visits daily. Resident #1 uses grab bars on side of bed to get in and out of bed and to turn and reposition. Resident #1 sustained a fall on the weekend (06/22/24). After the fall, the grab bars were discontinued. Resident #1 was still able to get in and out of bed. During an interview on 07/08/24 at 4:58 PM, with LVN D, revealed, stated Resident #1's family member visits daily on the evening shift. LVN D reported resident was alert, oriented to person, place, and recognized familiar people. Resident #1 was able to verbalize needs and was able to make decisions. It was reported that the Resident bangs on the wall with a cup for help. Resident #1 can use her call light and does not know why Resident #1 bangs on the wall for help. LVN D reported resident frequently attempts to toilet without assistance. Resident #1 was sent to the hospital 2 weeks ago on the night shift because she was found on the floor and sustained a skin tear to the left arm and a fractured left wrist. Resident #1 had Grab Bars on her bed to turn and reposition, and to get in and out of bed on her own. After the incident she got a different bed, and the Grab Bars were removed. Resident #1 was still able to get in and out of bed on her own. She continues to require close supervision and re-direction, so she does not attempt to use the toilet without assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview and observation on 07/09/24 at 6:09 AM, with LVN B, stated on the 10-6 shift revealed, she was assigned to Resident #1 on the day of the incident on 06/22/24. LVN B demonstrated to the surveyor, that Resident #1 was found on the floor on the fall mat, her legs were bent at the knees, and her buttocks were on lower legs, on her calfs in a sitting position facing the bed and was holding the grab bar with her left hand, and her arm was stuck slightly above the elbow joint between the mattress and the grab bar. The plastic bracelet on her left arm was caught in the skin tear on the left arm. LVN B stated, she was walking down the hall towards the decentralized nursing station, two doors from resident's room and heard someone moaning and yelling out. When I went to check to see who was yelling. Upon entering Resident #1's room, I noted that her left arm was stuck between the mattress and the Grab Bar on the side of the bed. I told the resident that I needed to go and get help. As I was walking out of the room, I noted the CNA was charting at the decentralize station, so I called her to come and help me. There was not a gap between the mattress or the Grab Bar. We had to slightly lift the mattress to release the arm. Resident #1 did not complain of pain upon assessment and did not have guarded movement. Resident had a superficial skin tear to the left arm, wound was cleaned with normal saline and applied steri-strips. I completed an Event Report and Interact SBAR Communication Form and notified physician, responsible party, and DON. The family member did not voice any concerns on that day. LVN B reported putting the resident back to bed, she appeared to be very sleepy and was not fully awake, she kept grabbing down the side of the bed with her right arm, like if she was looking for something. We noted resident had had a bowel movement when we put her back to bed. An x-ray was done on the morning shift on that day. On that day, she had complained of knee pain prior to the incident and was medicated with Acetaminophen as ordered for pain. Medication was effective. Resident did not complain of pain, the rest of the shift on that day. LVN B reported that prior to the incident, resident was able to get in and out of bed by using the Grab Bar on the sides of the bed, had an unsteady gait, was confused at times, was oriented to person, place, and recognizes familiar people, and was able to verbalize needs. The resident sleeps most of the night, occasionally gets out of bed and propels her wheelchair to the bathroom and attempts to toilet without assistance. Sometimes, she gets up at night and will propel her wheelchair up and down the halls. Resident requires close supervision and re-direction as needed. It was reported that resident had a history of falls. Rounds were made every 2 hours by the nurses and CNAs. It was reported that resident was at Risk for falls prior to incident. Resident occasionally uses the call light or bangs on the wall with her hand or the call light when she wants help. During an interview on 07/09/24 at 11:22 AM, with CNA A, revealed, Resident #1 was alert, confused at times, able to verbalize needs, very impulsive, frequently gets in and out of bed by holding on the grab bars on the side of the bed and uses the grab bars to turn and reposition in bed. Resident #1 also frequently attempts to toilet without assistance. Resident #1 requires close supervision and re-direction. CNA A stated nursing staff encourage Resident #1 to go to the toilet when they go to her room during scheduled rounds. She does not call for help. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation and interview on 07/09/24 at 3:28 PM, revealed, the family member was visiting Resident #1. The Family member reported that Resident #1 had fallen from the bed, sustained a big skin tear on her left arm, fractured her arm and hip. After the fall, they changed her bed and removed the grab bars on side of the bed. The Family member stated, Now, the resident is no longer able to get out of bed on her own or turn and re-position while in bed since they removed the grab bars on the side of the bed. The Family member reported Resident #1 did not feel safe without the Grab Bar on the side of the bed and was afraid of falling when she got out of bed. Resident #1 was sent to the emergency room , and they kept her over-night. The x-ray and CT scan revealed a hip fracture. In the hospital they did an MRI and the doctor reported that there was no right hip fracture, and that Resident #1 had a large contusion (is a bruise caused by a direct blow to the body that causes damage to the surface of the skin and to deeper tissues as well depending on the severity of the blow) on her hip. Interview and record review on 07/10/24 at 1:05 PM, with the DON, stated Resident #1's bed was changed to a high/low bed and that was not as wide as the bed that she had when she sustained the fall on 06/22/2024. The DON reported the day of the incident on 06/22/24, Resident #1 was found by LVN B, the night nurse on the floor, by the side of the bed with one of her arms caught between the mattress and the grab bar that was attached to the side of the bed. Resident #1 sustained a skin tear to the left forearm. The DON reported that the resident had not complained of pain at the time of the initial assessment that was completed by the night nurse (LVN B). Later in the day, Resident #1 complained of having pain to her right leg and x-rays were ordered. The X-Rays revealed Resident had a fracture to the left wrist and right hip. Resident #1 was sent to the hospital for evaluation and was admitted . The hospital reported MRI revealed Resident #1 did not have a hip fracture and had a contusion to the right hip. Resident #1 returned to the facility on [DATE] with a diagnosis of left wrist fracture and contusion to right hip. The DON reported facility had a meeting with Resident #1's family member and the Ombudsman when the decision was made to remove the Grab Bars on the side of the bed and Resident #1's family member had agreed with the recommendation to remove the Grab Bars. The DON stated, the facility did not document this meeting in the resident's electronic clinical record, we should have. The DON stated she did not remember the date of the meeting. The DON stated, she did not find a physician's order listed in the Physician Order Summary Report dated July 08, 2024, Order Date Range: 04/01/24 - 07/31/24 to use Grab bars on the side of the bed as an enabler. The DON stated, the facility needed to have a physician's order to use the Grab Bars on the side of the bed as an enabler, according to facility's policy on use of bed rails. We do not have a signed consent from the responsible party for Resident #1 to use Grab Bars on the side of the bed. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a telephone interview on 07/11/24 at 10:16 AM, with CNA K, reported she was on duty on the day of the incident involving Resident #1. CNA K stated, she was making rounds and went to check if resident was asleep, because she has the tendency to get out of bed without assistance. The resident was asleep, and noted that her legs were uncovered, so she covered her feet with her blanket and left the room. CNA K went to the decentralize nurse's station to do my charting because it was almost time for me to make my next round. The decentralized station is at the end of the hall, two rooms from Resident #1's room. CNA K was charting, when I heard someone was yelling louder than before, I thought it was Resident #1 that was yelling. That is when LVN B was coming down the hall towards the decentralize nurse's station, and she went to check the rooms to see who was yelling. When LVN B entered Resident #1's room, she came out right away and asked me to go to the room to help her. Upon entering the room, CNA K noted resident was on her knees and her buttocks were resting on her calfs, on the floor facing her bed and noted resident's arm was caught between the Grab Bar and the mattress. It appeared like she had flipped out of bed. We slightly lifted the mattress to remove the left arm from between the mattress and the Grab Bar. CNA K reported that there was no gap between the mattress and the Grab Bar. Resident #1 had a big skin tear to her left arm, that was caused by the Fall Risk bracelet that was stuck on her skin where the skin tear was on the arm. It appeared that the bracelet had sliced the skin to the arm, where the bracelet got stuck. We cut the bracelet off, and LVN I treated the skin tear. LVN B and CNA K put the resident back to bed and was not fully awake. The resident kept saying her family member and kept saying the family member had fallen with her and wanted to know where he was. Then the resident kept saying that her family member had also fallen with her and wanted to know where he was. The incident happened approximately, 1 minute after I had left the room and went across her room to room [ROOM NUMBER] to check on Resident #2. The incident with Resident #1 happened real fast right after I left her room. The Resident #1 was still able to get out of bed after the incident, without the Grab Bars. It was reported that the resident sleeps most of the night, but occasionally she does get out of bed to attempt and use the toilet unassisted. She will sit in her wheelchair and propel the wheelchair with her feet to the bathroom. CNA K reported that in between rounds, she made visual rounds to check up on those residents that attempt to get up without assistance and require close supervision and re-direction. It was reported that Resident #1 requires close supervision and re-direction, because she has a history of falls and will get out of bed without assistance to attempt to use the bathroom without assistance. CNA K reported Resident #1 has had the Grab Bars on her bed, since she started working at the facility 7 months ago. Record review of the facility Incidents and Accents policy not dated, revealed, It was policy of this facility for staff to utilize to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Accident - refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Policy Explanation: Assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement to avoid further occurrences. Record review of the facility Fall Prevention Program policy dated 07/01/22, revealed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	High Risk Protocols: Indicate fall risk on care plan. Provide interventions that address unique risk factors measured by the risk assessments tool. Provide additional interventions as directed by the resident's assessment including but not limited to - low bed and assistive devices. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. Record review of facility's policy & procedure on Proper Use of Bed Rails implemented 07/2022 revealed, Topic: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. Bed Rails are adjustable or rigid plastic bars that attach to the bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Entrapment - was an event in which a resident was caught, trapped, or entangled in the space in or about the bed rails. Resident Assessment: As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meet those needs: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, sleep habits, ability to toilet self safely, cognition, communication, mobility (in and out of bed), risk for falling. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include - Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). Barriers to resident from safely getting out of bed. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rails or in the bed rail itself. Observation and interview on 07/24/24 at 11:23 AM, of hall 110 revealed, room [ROOM NUMBER] had Resident #1 in bed A. Resident #1 was in bed A with the bed low, but no fall mat placed next to her. There were no grab bars (enablers) attached to Resident #1's bed either. Resident #1 was mumbling words but could not understand what was being said. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/24/24 at 1:11 PM, with the ADON, she stated Resident #1 had a fall on 06/22/24. The ADON stated the facility placed Resident #1's bed low and placed a fall mat next to the bed anytime Resident #1 was in bed. The ADON stated the staff had been trained to place the fall mat next to the bed when Resident #1 was in bed. The ADON stated during Resident #1's fall she had acquired a fracture on her left wrist. The ADON stated when state agency observed no fall mat on 07/24/24, that there should have been a fall mat placed. The ADON stated the grab bars (enablers) were removed due to Resident #1 getting her hand caught when having the fall, and they were no longer appropriate. During an interview on 07/25/24 at 8:27 AM, with the Physician, she stated Resident #1 was a high risk for falls. The Physician stated the bed should have been lowered towards the ground and the fall mat placed next to the bed to prevent the risk of Resident #1 hitting the hard floor which could add to the impact of the fall. The Physician stated she was uninformed of the laceration to the left forearm and the left hand being caught on the bed for Resident #1 by LVN B. The Physician stated it was expected for the nursing staff to inform her of all the information of a fall regarding Resident #1. During an interview on 07/25/24 at 3:10 PM, with the DON, she stated the day of the incident 06/22/24, Resident #1 did not have a high low bed like she has right now. The DON stated the Resident #1's bed would not go all the way down. During an interview on 07/25/24 at 3:17 PM, with MDS Coordinator CC, she stated the purpose of a care plan was designed for the type of care the residents are to get. MDS Coordinator CC stated if a resident had it in their care plan to place the fall mat next to the bed and lower the bed when resident was in it then it would have to be done. MDS Coordinator stated the risk of not following the care plan not placing the fall mat next to the bed and not lowering the bed could result in harm to the resident(s). During an interview on 07/25/24 at 3:20 PM, with the MDS Coordinator BB and Director of Reimbursement. The Director of Reimbursement stated she could not find physician orders for the fall mat and lowering of the bed for Resident #1. The Director of Reimbursement stated the care plan orders were not discontinued and Resident #1's intervention to place the fall mat next to the bed and lower the bed were still active. The Director of Reimbursement stated the risk of not lowering the bed and placing the fall mat next to the bed could result in harm to the resident. Record review of Resident #1's video reviewed on 07/25/24 at 8:55 PM - Video was review for 06/22/24 fall incident of Resident #1. - 12:30:53 AM - Resident #1's right arm was dangling downwards as if to pick up something off the ground. There was a trash can next to the head of bed area, a tray table next to the bed of Resident #1, and no fall mat was placed next to the bed. Bed was not in a low position. Next to the trash can was a dark unknown substance. - 12:30:55 AM - Resident #1 is seen grabbing the bed rail with her right hand. Cannot see left hand/arm. - 12:31:00 AM - Resident #1 was on bed closest to the restroom and entrance door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- 12:31:00 AM - Resident #1 was seen turning to her left side (body). Tray table was seen close to resident. No floor mat seen. Bed is raised (not low position). Bed rail is up. - 12:31:02 AM - Resident #1 was wearing dark socks. Residents' feet touched the floor. - 12:31:03 AM - Resident #1 tried to stand up, but legs gave out. - 12:31:04 AM - Resident #1 hit the tray table with her right arm moving the tray table and hit the trash can also moving the trash can that was on the floor next to the bed. Left hand was stuck (trapped) in between the mattress and the bed rail. Resident's feet slid underneath the bed and butt hit the floor. Loud sounds could be heard as Resident #1 hit the tray, trash can, and floor. - 12:31:23 AM - Resident #1 could be seen moving and moved the tube feeding stand as the flush bag was seen moving back and forth. - 12:31:31 AM - Resident #1's right side arm was on the trash can and then the trash can tips sideways causing Resident #1 to fall down from her shoulders and head to the floor making a loud sound. The feeding stand was also moved at the same time. The flush bag was seen moving back and forth. - 12:31:38 AM - There was another loud sound that was made but nothing could be seen to know what was moved. - 12:31:58 PM - Resident was lying on her right-side hip and head was seen moving downwards and upwards in the air. Right shoulder arm was not [NAME] in the lying down position. Both legs and half of her body sideways was underneath the bed. Left arm/hand was still caught between the mattress and grab bars (enablers). - 12:32:21 AM - Resident #1's height of bed was at the mid-section of the white scratches that were on the wall exposing the white wall where paint was coming off. - 12:32:46 AM - Resident #1 was seen moving her legs upwards into a fetal position underneath the bed. Resident #1 was not heard calling for help. Resident #1 was still hook and lying sideways on her right side. - 12:33:11 AM - Resident moves her right arm and positions herself to lean on it. Resident #1's right elbow was touching the floor and her head was raised upwards in a diagonal angle to the right side of her body. - 12:34:06 AM - Resident #1 was seen leaning backwards and still on her right elbow, legs underneath the bed towards the headboard area. - 12:35:22 AM - Resident #1 was not yelling and in the same position as above. - 12:37:27 A [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 (Resident #1) of 1 resident observed for oxygen management. Resident #1 was on oxygen without a physician's order. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health; and place them at risk of an unsafe environment which could lead to accidents and injuries. Findings included: Resident #1 Record review of the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Record review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension. Record review of the Quarterly MDS dated [DATE] for Resident #1 completed by Director of Reimbursement revealed MDS did not document resident #1 was receiving oxygen. Record review of the Care Plan revised 02/10/21 for Resident #1 revealed, care plan did not document resident was receiving oxygen. Record review of the Physician Order Summary Report dated for Resident #1 revealed, Order Date Range: 04/01/24 - 07/31/24. revealed there was no order for oxygen. Review of the Medication Administration Record dated May 2024 for Resident #1 revealed, Start Date: 08/23/2022 Oxygen at 2-3 liters via nasal cannula prn for shortness of breath and dyspnea. Observation on 07/08/24 at 4:50 PM, revealed Resident #1 was propelling her wheelchair in her room with her hands and feet towards the bathroom and was attempting to open the bathroom door. The portable oxygen cylinder was attached to the back of the wheelchair. Interview on 07/09/24 at 3:01 PM with the DON, revealed the two MDS nurses had quit at the same time, and they had just hired two new MDS nurses that were in training due to not having experience with completing MDS forms. The DON confirmed that Quarterly MDS assessment completed on 05/21/24 by Director of Reimbursement did not document Resident # 2 was receiving oxygen. In an interview and record review on 07/10/24 at 1:05 PM, with DON confirmed Physician Order Summary Report for Resident #1 did not document an order for oxygen.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review the facility failed to assess the resident for risk of entrapment from an enabler (bed rail) prior to installation or review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 (Resident #1) of 5 residents reviewed for enablers (bed rails/grab bars). On [DATE], Resident #1 fell out of bed at 12:31:04 AM - Resident #1 was noted to have an enabler (bed rail/grab bar) connected to the upper area of her bed. Resident #1's Enabler assessment dated [DATE], revealed, that it was incomplete. The digital form was not signed nor was there any input in the questions such as, Was there a risk to the resident if enablers are used? (all left blank). This failure could place residents who have grab bars (enablers) at risk of having inappropriate or unnecessary enablers in place, increasing their risk of injury. Findings included: Record review of Resident #1's Admission Record dated [DATE] revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Record review of Resident #1's Hospital History & Physical dated [DATE] revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to our hospital due to fall. Patient had an accidental mechanical fall 2 days ago from her bed, when she rolled from her bed. Her left hand was caught in the handrail and landed on her left lower limb. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMS Score 06, (severely cognitively impaired), no behavior symptoms, wheelchair, ADLs-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Requires partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel; No falls since admission. Not marked for bed rails. Record review of Resident #1's Enabler assessment dated [DATE] revealed, that it was incomplete. Commented that Resident #1's, level of consciousness or cognitive deficit was yes and stated forgetful/confused at times. Was there a risk to the resident if enablers are used? - Was left blank. There was no signature of Resident, guardian, or Legal Representative. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Enabler assessment dated [DATE], revealed, that it was incomplete. The digital form was not signed nor was there any input in the questions such as, Was there a risk to the resident if enablers are used? (all left blank). Record review of Resident #1's Physical Therapy Evaluation and Plan of Treatment dated [DATE], revealed, Resident #1 was supervision with transfers prior but was now a high fall risk due to trying to transfer without adequate strength. : Gross Motor Coordination = Impaired. Clinical Impressions: [AGE] year-old female who had decreased strength, coordination, and balance. Instructed patient and primary caregivers in safety sequencing techniques, safe bed mobility/transfers techniques, safety precautions and compensatory strategies to increase safety Record review of Resident #1's Care Plan revised [DATE] revealed Cognitive Impairment-short term memory r/t dementia. Revised [DATE] Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: [DATE] Continue with bed to lowest position with floor mat next to bed. [DATE] Actual Fall. Interventions: Sent to emergency room . Ordered x-rays. [DATE] Bed will continue to be kept to lowest position while pt. is on bed to prevent further falls. [DATE] Fall mat next to bed. [DATE] Instruct resident to call for help before getting out of bed or chair. Always keep call light in reach, visible to resident and the resident is informed of its location and use. Revised [DATE] Require one person assistance with ADLs r/t cognitive deficit. Revised: [DATE] May use enablers x 2 to assist with turning & repositioning and enhance independence. There was no care plan for enablers noted. Record review of Resident #1's Physician Order Summary Report dated [DATE] at 5:28 PM revealed, Order Date Range: [DATE] - [DATE] Physician Order Summary did not document an order for use of grab bars. Record review of Resident #1's Event Report dated [DATE] at 1:00 AM written by LVN I revealed, Incident Description Nursing Description: heard yelling from hall. Nurse entered room and observed her on the floor with left arm in[sic] the siderail. Resident Description: She doesn't know what she was doing. She thinks she was just turning over and slipped off the bed. Immediate Action Taken Description: Assessed for injuries. X2 [sic] assist to bed. Assessed left arm and found 3-inch skin tear to forearm. Area cleansed with normal saline. Skin protectant applied. Edges approximated and secured with steri-strips. Nonstick dressing and kerlix applied as secondary dressing. Neuro checks initiated. Predisposing Situation Factors-Other, Side Rails up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic Nurse Progress Note dated [DATE] at 1:44 AM, written by LVN I revealed, heard resident yelling from hallway. Nurse went to investigate. Found resident on resident on the sitting [sic] on the floor with her left arm in the enabler. With 2 assist, [sic] was removed from enabler. Assessment conducted. 2 assist [sic] to bed. Resident doesn't know what happened. She thinks she was just rolling over. She was soiled with BM. This nurse believes she may have been trying to go to the restroom. This nurse pulled up her sleeve and found a 3-inch skin tear to her left forearm. She had a Fall Risk band in place. Arm band removed. As it may have contributed to the skin tear. Area cleansed with NS. Skin prep barrier. Edges approximated and secured with steri-strips (thin adhesive bandages used for skin closure). Secondary dressing applied, non-stick dressing and kerlix. Neuro checks initiated and WNL (within normal limits). [family member], MD and DON notified. Record review of Resident #1's SBAR INTERACT form dated [DATE] at 1:30 AM for Resident #1 written by LVN I revealed, The Change of Condition: Fall. Since this started it has gotten: Stayed the same. Primary Diagnoses is Urinary Tract Infection, dementia, diabetes mellitus. Outcome of Physical Assessment: Mental Status Evaluation: No changes observed. Functional Status Evaluation: Fall (one or more). Skin Status Evaluation: Skin Tear. Review of Resident #1's Nurse Progress Note dated [DATE] at 7:59 AM, written by RN L, revealed Per attending nurse pt. s/p fall resulting in a skin tear to left forearm. Area assessed and measured L 4 cm x W 1. 5 cm, unable to assess depth. Noted skin tear with edges well approximated with steri-strips in place. Wound care performed as ordered. Pt. tolerated well. Review of the Nurse Progress Note dated [DATE] at 1:00 PM written by LVN E, for Resident #1 revealed, resident had a fall on ,d+[DATE] prior to day shift. Ordered stat x-ray of lumbar spine, pelvis, bilateral hips, left forearm for pain related to fall. X-ray completed on [DATE] with abnormal results, acute and suspected fractures. Consulted with attending physician and [family member]. ADON notified. Resident to be transferred to hospital. Record review of Resident #1's hospital MRI dated [DATE], revealed, it was reported that the x-ray along with the CT scan and MRI, did not see any evidnce of a fracture on the MRI. There was questionable concern of CT scan of an area of the lesser trochanter that was fractuered. However seh does have a chronic great trochanter fracture along with bruising. There was no evidnce of fracture here. During an interview on [DATE] at 8:43 AM, with LVN J, revealed Resident #1 was alert, oriented to person and place. Resident #1 was chairbound and propels her wheelchair with her feet independently. Resident #1 transfers independently from bed to chair and chair to bed. Resident #1 toilets independently and uses call-light for assistance. Residents are checked every two hours by nurses and CNAs. LVN J reported CNAs stay at the decentralized stations to monitor residents and answer call-lights when they are doing their charting. LVN J reported that Resident #1 was impulsive and requires close supervision and re-direction. Resident #1 can verbalize needs. Resident #1's family member visits daily. Resident #1 uses grab bars on side of bed to get in and out of bed and to turn and reposition. Resident #1 sustained a fall on the weekend ([DATE]). After the fall, the grab bars were discontinued. Resident #1 was still able to get in and out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:58 PM, with LVN D, revealed, stated Resident #1's family member visits daily on the evening shift. LVN D reported resident was alert, oriented to person, place, and recognized familiar people. Resident #1 was able to verbalize needs and was able to make decisions. It was reported that the Resident bangs on the wall with a cup for help. Resident #1 can use her call light and does not know why Resident #1 bangs on the wall for help. LVN D reported resident frequently attempts to toilet without assistance. Resident #1 was sent to the hospital 2 weeks ago on the night shift because she was found on the floor and sustained a skin tear to the left arm and a fractured left wrist. Resident #1 had Grab Bars on her bed to turn and reposition, and to get in and out of bed on her own. After the incident she got a different bed, and the Grab Bars were removed. Resident #1 was still able to get in and out of bed on her own. She continues to require close supervision and re-direction, so she does not attempt to use the toilet without assistance. During an interview on [DATE] at 11:22 AM, with CNA A, revealed, Resident #1 was alert, confused at times, able to verbalize needs, very impulsive, frequently gets in and out of bed by holding on the grab bars on the side of the bed and uses the grab bars to turn and reposition in bed. Resident #1 also frequently attempts to toilet without assistance. Resident #1 requires close supervision and re-direction. CNA A stated nursing staff encourage Resident #1 to go to the toilet when they go to her room during scheduled rounds. She does not call for help. Observation and interview on [DATE] at 3:28 PM, revealed, the family member was visiting Resident #1. The Family member reported that Resident #1 had fallen from the bed, sustained a big skin tear on her left arm, fractured her arm and hip. After the fall, they changed her bed and removed the grab bars on side of the bed. The Family member stated, Now, the resident is no longer able to get out of bed on her own or turn and re-position while in bed since they removed the grab bars on the side of the bed. The Family member reported Resident #1 did not feel safe without the Grab Bar on the side of the bed and was afraid of falling when she got out of bed. Resident #1 was sent to the emergency room , and they kept her over-night. The x-ray and CT scan revealed a hip fracture. In the hospital they did an MRI and the doctor reported that there was no right hip fracture, and that Resident #1 had a large contusion (is a bruise caused by a direct blow to the body that cause damage to the surface of the skin and to deeper tissues as well depending on the severity of the blow) on her hip. Interview and record review on [DATE] at 1:05 PM, with the DON, stated Resident #1's bed was changed to a high/low bed and that was not as wide as the bed that she had when she sustained the fall on [DATE]. The DON reported facility had a meeting with Resident #1's family member and the Ombudsman when the decision was made to remove the Grab Bars on the side of the bed and Resident #1's family member had agreed with the recommendation to remove the Grab Bars. The DON stated, the facility did not document this meeting in the resident's electronic clinical record, we should have. I do not remember the date of the meeting. The DON stated, she did not find a physician's order listed in the Physician Order Summary Report dated [DATE], Order Date Range: [DATE] - [DATE] to use Grab bars on the side of the bed as an enabler. The DON stated, the facility needed to have a physician's order to use the Grab Bars on the side of the bed as an enabler, according to facility's policy on use of bed rails. We do not have a signed consent from the responsible party for Resident #1 to use Grab Bars on the side of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 10:16 AM, with CNA K, reported Resident #1 was still able to get out of bed after the incident, without the Grab Bars. It was reported that the resident sleeps most of the night, but occasionally she does get out of bed to attempt and use the toilet unassisted. She will sit in her wheelchair and propel the wheelchair with her feet to the bathroom. CNA K reported that in between rounds, she made visual rounds to check up on those residents that attempt to get up without assistance and require close supervision and re-direction. It was reported that Resident #1 requires close supervision and re-direction, because she has a history of falls and will get out of bed without assistance to attempt to use the bathroom without assistance. CNA K reported Resident #1 has had the Grab Bars on her bed, since she started working at the facility 7 months ago. Observation on [DATE] at 11:23 AM, of hall 110 revealed, room [ROOM NUMBER] had Resident #1 in bed A. Resident #1 was in bed A with the bed low. There were no grab bars (enablers) attached to Resident #1's bed. Resident #1 was mumbling words but could not understand what was being said. During an interview on [DATE] at 1:11 PM, with the ADON, she stated Resident #1 had a fall on [DATE]. The ADON stated the grab bars (enablers) were removed due to them being determined to be no longer appropriate. Observation and interview on [DATE] at 2:45 PM, with the Maintenance Director. Maintenance Director was observed going into residents' rooms in hall 300 and taking off bed rails from resident beds and was placing them on a cart. Maintenance Director stated he was asked by the Administrator to go into the residents' rooms that where audited and follow the list given to him by the Administrator, of residents who do not need bed rails (enablers) but have them on. The Maintenance Director stated he had just started working on [DATE] and was not notified by the outgoing Maintenance Director or anybody to monitor or conduct monthly checks on the bed rails. The Maintenance Director stated he did not have in his office any instructions or manual for the bed rails. The Maintenance Director stated there could be a risk if monthly checks or monitoring of the bed rails were not being done such as faulty equipment or equipment needing repair. The Maintenance Director stated he did not know if there was any risk to the residents who had bed rails on and did not need them. During an interview on [DATE] at 1:34 PM, with the Director of Rehabilitation, she stated she began working for the facility in ,d+[DATE], and the therapy department was not doing assessments on residents with enablers since she started working there. The Director of Rehabilitation stated when the previous Surveyor left the facility at the beginning week of [DATE], that was when the facility notified her to start auditing the residents with enablers. The Director of Rehabilitation stated the department had completed the list on [DATE]. The Director of Rehabilitation stated before the facility was conducting Enabler Assessments that were being done by the nurses. The Director of Rehabilitation stated the grab bar or enabler was called an adaptive equipment per therapy department language and was equipment that the resident would use to be able to reposition themselves. The Director of Rehabilitation stated the Family Member had requested that Resident #1 use the grab bars (enablers). The Director of Rehabilitation stated she that it was a must to assess residents with enablers to see if they were appropriate for use or not as an enabler. The Director of Rehabilitation stated the risk of not doing the enabler assessments could be obstructive to the resident(s) depending on what the enabler was. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:25 PM, with Central Supply/Medical Records Director, he stated he had not seen any bed rails or instructions for the bed rails. Central Supply/Medical Records Director stated he was shown how to install the bed rails by the outgoing Maintenance Director. The Central supply /Medical Records Director stated the risk of not having instructions or a manual guide was missing something from the bed rails. The Central Supply/ Medical Records Director stated he was not told to conduct monitoring checks on the bed rails. The Central Supply/ Medical Records Director stated there was no logs for checking the bed rails. During an interview on [DATE] at 8:27 AM, with the Physician, she stated Resident #1 was a high risk for falls. The Physician stated the bed should have been lowered towards the ground and the fall mat placed next to the bed to prevent the risk of Resident #1 hitting the hard floor which could add to the impact of the fall. The Physician stated that she believed that Resident #1 was appropriate for use of the grab bars (enablers). During an interview on [DATE] at 10:39 AM, with Occupational Therapy, he stated the therapy department had discussed on [DATE]-[DATE], that the department was going to be tasked with conducting enabler assessments on resident(s) to see if they were deemed appropriate for the use of the grab bars (enabler). Occupational Therapy stated they would be checking for a residents' functional mobility which includes bed mobility, sit to stand. The Occupational Therapy stated the assessment was conducted by a questionnaire on the facility system combined with their physical evaluation of the resident. Occupational Therapy stated he would assume that the residents would require a physician order for the grab bars (enablers). The Occupational Therapy stated that before the fall Resident #1 was able to use the grab bars (enabler). Record review of facility's policy & procedure on Proper Use of Bed Rails implemented ,d+[DATE] revealed, Topic: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. Bed Rails are adjustable or rigid plastic bars that attach to the bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Entrapment - was an event in which a resident was caught, trapped, or entangled in the space in or about the bed rails. Resident Assessment: As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meet those needs: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, sleep habits, ability to toilet self safely, cognition, communication, mobility (in and out of bed), risk for falling. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include - Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). Barriers to resident from safely getting out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident assessment should assess the resident's risk of entrapment between the mattress and bed rails or in the bed rail itself. Record review of the facility Bed Assist Bars Instructions Manual dated 2008, revealed, Entrapment Warning - Proper patient assessment and monitoring, and proper maintenance and use of equipment was required to reduce the risk of entrapment. Record review of the Manufacturers' Manual not dated, revealed, Danger! - risk of Death, Injury, or Damage: Proper patient assessment and monitoring, and proper maintenance and use of equipment was required to reduce the risk of entrapment. Record review of the FDA website http://www.fda.gov not dated, revealed, A Guide to Bed Safety Bed Rails in hospitals, Nursing Homes and Home Health Care: The Facts - Bed Rail Entrapment Statistics - Between 1985 and [DATE], 803 incidents of patients caught, trapped, entangled, or strangled in beds with rails were reported to the U.S. Food and Drug Administration. Of these reports, 480 people died , 138 had a nonfatal injury, and 185 were not injured because staff intervened. Most patients were frail, elderly or confused. Potential risks of bed rails may include: Strangling, suffocating, bodily injury or death when patient or part of their body are caught between rails or between the bed rails and mattress. Skin bruising, cuts, and scrapes. Which ways of Reducing Risks are Best? - A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety. Reassess the need for using bed rails on a frequent, regular basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #2 and Resident #3) of 6 reviewed for medication administration in that: -The facility failed to immediately consult with physician and/or Nurse Practitioner when the facility did not have 7 doses of the prescribed IV antibiotics on hand to administer to Resident #2 according to physician's orders. -The facility failed to immediately consult with physician and/or Nurse Practitioner when the facility did not have 8 doses of the prescribed IV antibiotics on hand to administer to Resident #3 according to physician's orders. This failure put residents at risk of delayed medical treatment. Findings include: Resident #2 Review of the Admission Record dated 07/08/24 revealed, Resident #2 was initially admitted on [DATE] and readmitted [DATE]. Review of the Annual History & Physical dated 08/01/23 for Resident #2 revealed an [AGE] year-old female with diagnoses of hypertension, dementia, anxiety, epilepsy, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), stenosis of peripheral vascular stent (a stent is a permanent device that's inserted to keep blood flowing) stable (stenosis is a narrowing of the arteries in the legs and feet, malignant epithelial neoplasm of vulva (a cancer of the external genitals), encephalopathy (is a serious neurological condition that occurs when the brain is damaged or diseased causing brain function to change). Alert, oriented to person. Review of the Quarterly MDS dated [DATE] for Resident #2, revealed Atherosclerosis with unspecified Angina Pectoris (Thickening or hardening of the arteries, with chest pain or discomfort when heart muscle does not get enough blood). Incontinent of bowel & bladder. Review of the Care Plan revised 06/27/23 for Resident #2 revealed, At Risk for UTIs (Urinary Tract Infection) r/t incontinent of bowel & bladder due to poor cognition. Interventions: Administer meds per MD order. Review of the Physician Order Summary Report dated July 08, 2024, for Resident #2 revealed Order Range: 04/01/24 - 07/31/24. -Order Date: 06/14/24. Start Date: 06/15/24 Clindamycin Phosphate in NaCl (sodium chloride) intravenous solution 300-0.9 mg/50 ml intravenously three times a day for UTI infection for 7 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date: 06/17/24. Start Date: 06/17/24 Clindamycin HCl Oral Capsule 300 mg give 1 capsule by mouth three times a day for UTI for 10 days. Review of the electronic Nurses Progress Notes for Resident #2 revealed: -06/14/24 at 9:41 PM INTERACT SBAR Summary form (provides a framework for communication between health care team about a patient's condition) written by LVN D reflected Clindamycin 300 mg IV 3 x a day for 7 days for UTI. -06/15/24 at 12:59 PM note written by LVN E reflected, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available. -06/15/24 at 5:39 PM note written by LVN E reflected, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. -06/15/24 at 7:27 PM note written by LVN E reflected, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. Record review revealed the facility did not have any written documentation in the electronic Nurses Progress Notes that documented Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) was not available to administer according to physician's order on 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM and 06/17/24 at 8:00 AM. Record review revealed the facility did not have written documentation in Resident #2's electronic Nurses Progress Notes that documented the attending physician and/or NP were notified Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) was not available to administer according to physician's order on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. Review of the Medication Administration Record (MAR) dated June 2024 for Resident #2 revealed: -Order Date: 06/14/24 for Clindamycin Phosphate 300-0.9 mg/50 ml in sodium chloride solution intravenously three times a day for UTI for 7 days. The MAR reflected the medication was not administered on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. IV Clindamycin Phosphate was discontinued on 06/17/24 and was changed on 06/17/24 to Clindamycin HCL 300 mg give 1 capsule by mouth three times a day for UTI x 10 days. Telephone interview on 07/08/24 at 7:43 AM, with the family member for Resident #2 revealed, that the nurses did not give her IV antibiotics as ordered by the physician. Telephone interview 07/10/24 at 8:50 AM, with the attending physician for Resident #2 revealed, that he expected the licensed staff to report to the physician and/or NP if the prescribed medication had not been administered as ordered due to the lab not coming to draw blood for ordered labs and/or not sending lab results on a timely basis to determine if Vancomycin IV could be administered as ordered. The Physician stated that licensed staff could not order labs without a physician's order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confidential interview on 07/11/24 at 11:01 AM, revealed Resident #2 had a physician order for Clindamycin IV to treat a UTI. The medication was not given as ordered because the medication was not delivered by the pharmacy and the medication was not on hand in the Emergency Kit. It was reported that the lab did not come on a timely basis to draw blood for the ordered labs and the IV medication could not be administered until labs have been done and results have been received and reported to physician. Resident #3 Closed Record review of the Admission Record dated 07/09/24 for Resident #3 revealed, original admitted : 06/06/24. Resident discharged home on 07/08/24 with Home Health Services. Review of the Initial Medical Visit dated 06/10/24 for Resident #3 revealed, [AGE] year-old-female discharge from the hospital where she was treated for right knee septic arthritis (is a painful infection in a joint that can come from germs that travel through your bloodstream from another part of your body) for which patient underwent a right knee irrigation and debridement (a process of removing dead skin and foreign material from a wound) on 05/25/24. The patient continues with Vancomycin 1000 mg/200 ml BID and Ceftriaxone 2 GM QD (daily) through PICC line (a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near your heart) to RUE (Right Upper Extremity). Active Medical Problems: Hypertension, Diabetes Mellitus type 2, Right knee irrigation and debridement on 05/25/24, Right knee arthroplasty (a surgery to restore the function of a joint) 06/20/23. Review of the Medical Visit dated 06/12/24 for Resident #3 revealed the resident underwent right knee arthrotomy (is a surgical exploration of a joint) with debridement and synovectomy with poly insert exchange (surgical removal of the membrane that lines a joint). Patient also seen by ID (Infectious disease doctor) recommending continue IV antibiotic for 6 weeks. Patient was admitted to our facility for PT and rehab. Review of the Admission MDS dated [DATE] for Resident #3, revealed clear speech, makes self-understood, understood others, vision adequate, BIMs score 15 (cognitively intact), used a wheelchair, occasionally incontinent of bowel & bladder; other major orthopedic surgery; surgical wounds; antibiotic and IV medications. Review of the Care Plan revised on 07/09/24 for Resident #3, revealed the resident was on IV (giving medicines or fluids through a needle or tube inserted into a vein) medications. Revised 07/09/24, the resident was on antibiotic therapy. Interventions: Administer ANTIBIOTIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Report pertinent lab results to MD. Review of the Physician Order Summary Report dated 07/09/24 at 3:08 PM, Order Date Range: 05/01/24 - 07/31/24 for Resident #3 revealed: -Order Date: Vanco trough every Friday. (A trough level is the concentration reached by a drug immediately before the next dose is administered, often used in therapeutic drug monitoring.) -Order Date: 06/06/24 Vancomycin HCl (antibiotic to treat bacterial infections) intravenous solution 1000 mg/200 ml every 12 hours for infection to surgical wound. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order Date: 06/13/24 Vancomycin HCl intravenous solution 1250 mg/250 ml every 12 hours for infection to surgical wound. -Order Date: 06/18/24 Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection). -Order Date: 06/24/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. -Order Date: 06/27/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. Review of a Grievance/Complaint Report dated 06/26/24 for Resident #3 written by the Social Worker revealed, Documentation of Grievance/Complaint related to Nursing Care. The resident stated that nursing staff were inconsistent with providing her antibiotics. Summary/Findings written by the DON on 06/26/24 revealed the medication required labs prior to every 3rd dose. The medication may change depending on results. Recommendations/Action Taken continue to draw labs as ordered and give the medication. Resolution of Grievance/Complaint Was grievance/complaint resolved? No. Family feels the facility should give medication at 8 AM and 8 PM regardless. Identify the method(s) used to notify the resident and/or representative of the resolution: Phone conversation. In an interview 07/09/24 at 3:59 PM, LVN F reported Resident #3 was at the facility for a very short stay and was discharged back home. The resident was alert and oriented to person, time, place, she was admitted for IV antibiotics, status post-surgery to right knee, due to the hardware got infected. LVN F stated, We had issues with the lab not sending the trough level results on a timely basis, which delayed timely delivery of the IV antibiotic. The resident also went out on frequent 4 hours passes with her family. The family member was very upset because the resident had missed the morning dose of the IV antibiotic. The family could not understand that the blood work needed to be done prior to administering the next dose of the IV medication so the dosage could be adjusted as need and could not understand that they could not double up on missed doses, because the medication was very toxic to the kidneys. LVN F stated the DON and ADON were aware that they were having problems with the lab provider not coming to draw blood as ordered and/or lab results were not sent to facility on a timely basis and resulted in residents not getting prescribed antibiotics as ordered. Telephone interview at 8:50 AM, with the attending physician for Resident #3 revealed that he expected the licensed staff to report to physician and/or NP if the prescribed medication had not been administered as ordered due to the lab not coming to draw blood for ordered labs and/or not sending lab results on a timely basis to determine Vancomycin IV can be administered as ordered. The Physician stated that licensed staff cannot order labs without a physician's order. The physician stated The licensed staff should immediately notify physician and/or the NP of a change in condition at which time a decision is made if labs will need to be ordered, depending on the resident's change in condition. It is very important that labs results are obtained as soon as possible to ensure that medical treatment is not delayed. Interview and record review on 07/12/24 at 2:53 PM, the Social Worker revealed she had talked to Resident #3 about her not getting her prescribed antibiotic as ordered. The Social Worker stated, I do not know why she was not getting her medication as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review of the electronic Nurses Progress Notes at 07/12/24 at 3:01 PM with the ADON for Resident #3 revealed IV antibiotic was not administered according to physician's orders due to lab results not received on time when the Vancomycin was scheduled to be administered and/or pending delivery from the pharmacy. ADON stated, That is why we are changing labs, because labs were not done on a timely basis or lab results were not received on a timely basis. The ADON confirmed that the facility did not have any written documentation in Resident #3's electronic Nurses Notes that documented physician was notified medication was not administered as ordered due to not having the medication on hand and/or labs not done on a timely basis and/or not receiving lab results on a timely basis to determine the dosage for the next medication administration. ADON reported Nurses had been trained to immediately notify the attending physician/NP/DON/ADON if medications were not administered as ordered and to document the notification in the Nurse's Progress Notes. revealed: -06/11/24 at 8:08 PM written by LVN F, revealed pending delivery from pharmacy. The pharmacy could not dispense the medication until the facility sent the result of the vanco trough to the pharmacy. -06/13/24 revealed the facility did not have any written documentation in the nurse's progress notes by LVN F that reflected Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered as documented on the MAR. -06/14/24 10:38 PM written by LVN F revealed, Vancomycin HCl intravenous solution 1250/250 ml for Osteomyelitis. Medication not available, pending delivery. -06/18/24 at 9:00 PM, revealed the facility did not have any written documentation in the nurse's progress notes by LVN F that reflected Vancomycin HCl intravenous solution 1250/250 ml was not administered as ordered as documented on the MAR. -06/19/24 at 7:32 AM, written by LVN G revealed Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Pending delivery. -06/21/24 at 3:13 PM, written by LVN F revealed the writer obtained results of Vanco trough that was drawn during previous shift and faxed them to the pharmacy twice. Pharmacy employee stated to ADON for the 300 hall that the results had not been received. When ADON asked if she could provide a verbal result the pharmacy employee stated she (ADON) would have to be transferred to the IV department. The ADON did not receive an answer but left a message for an individual at the pharmacy. Results were faxed a third time by the ADON, pending response. -06/21/24 at 9:06 PM, written by LVN F, revealed Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis. Increase to medication dose, pending delivery. -06/26/24 at 8:38 PM, written by LVN F, revealed Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee two times a day. Pending delivery of possible dose change. (continued on next page)

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Cimarron Park Nursing and Rehabilitation Center	7441 Paseo Del Norte El Paso, TX 79911

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/27/24 at 10:31 AM, Note Text written by LVN G revealed, the order was outside of the recommended dose or frequency. Vancomycin HCl 1750 mg/350 ml intravenously two times a day for infection to the right knee. The dose fails a general dose range check based on drug inputs and/or patient information provided. The drug's dose should be adjusted based on renal function. Manual screening was required. Interview and record review 07/12/24 at 3:07 PM the ADON confirmed that LVN G had initialed the MAR on 06/27/24 at 8:00 AM but did document if she had administered the medication as ordered. The ADON stated, I am not able to determine if Vancomycin HCl 1750 mg/350 ml intravenously was administered. There is no documentation in the resident's electronic Nurse's Progress Note that LVN G notified the physician, that medication was outside of recommended dose. -07/06/24 at 2:58 PM written by LVN H revealed, Vancomycin HCl intravenous solution 1750 mg/350 ml for infection to the right knee not given pending delivery from pharmacy. Confidential interview on 07/11/24 at 11:01 AM, revealed Resident #2 had a physician order for Clindamycin IV to treat a UTI. The medication was not given as ordered because the medication was not delivered by the pharmacy and the medication was not on hand in the Emergency Kit. It was reported that the lab did not come on a timely basis to draw blood for the ordered labs and the IV medication could not be administered until labs have been done and results have been received and reported to physician. Review of the facility's policy & procedure on Medication Administration implemented 07/22/2023 revealed, Policy: Medications are administered by licensed staff, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interviews, and record review, the facility failed to provide laboratory services to meet the needs of its residents, for 1 of 6 (Resident #3) residents reviewed for laboratory orders. -The facility failed to ensure that labs were done on a timely basis and lab results were promptly received to prevent delay in medical treatment for and for 8 doses of the prescribed IV antibiotics on hand to administer to Resident #3 according to physician's orders. This failure could place residents at risk for untreated medical conditions and diminished quality of care. Findings included: Resident #3 Closed Record review of the Admission Record dated 07/09/24 for Resident #3 revealed, original admitted : 06/06/24. Resident discharged home on 07/08/24 with Home Health Services. Review of the Initial Medical Visit dated 06/10/24 for Resident #3 revealed, [AGE] year-old-female discharge from the hospital where she was treated for right knee septic arthritis (is a painful infection in a joint that can come from germs that travel through your bloodstream from another part of your body) for which patient underwent a right knee irrigation and debridement (a process of removing dead skin and foreign material from a wound) on 05/25/24. The patient continues with Vancomycin 1000 mg/200 ml BID and Ceftriaxone 2 GM QD (daily) through PICC line (a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near your heart) to RUE (Right Upper Extremity). Active Medical Problems: Hypertension, Diabetes Mellitus type 2, Right knee irrigation and debridement on 05/25/24, Right knee arthroplasty (a surgery to restore the function of a joint) 06/20/23. Review of the Medical Visit dated 06/12/24 for Resident #3 revealed the resident underwent right knee arthrotomy (is a surgical exploration of a joint) with debridement and synovectomy with poly insert exchange (surgical removal of the membrane that lines a joint). Patient also seen by ID (Infectious disease doctor) recommending continue IV antibiotic for 6 weeks. Patient was admitted to our facility for PT and rehab. Review of the Admission MDS dated [DATE] for Resident #3, revealed clear speech, makes self-understood, understood others, vision adequate, BIMs score 15 (cognitively intact), used a wheelchair, occasionally incontinent of bowel & bladder; other major orthopedic surgery; surgical wounds; antibiotic and IV medications. Review of the Care Plan revised on 07/09/24 for Resident #3, revealed the resident was on IV (giving medicines or fluids through a needle or tube inserted into a vein) medications. Revised 07/09/24, the resident was on antibiotic therapy. Interventions: Administer ANTIBIOTIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Report pertinent lab results to MD. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician Order Summary Report dated 07/09/24 at 3:08 PM, Order Date Range: 05/01/24 - 07/31/24 for Resident #3 revealed: -Order Date: Vanco trough every Friday. (A trough level is the concentration reached by a drug immediately before the next dose is administered, often used in therapeutic drug monitoring.) -Order Date: 06/06/24 Vancomycin HCl (antibiotic to treat bacterial infections) intravenous solution 1000 mg/200 ml every 12 hours for infection to surgical wound. -Order Date: 06/13/24 Vancomycin HCl intravenous solution 1250 mg/250 ml every 12 hours for infection to surgical wound. -Order Date: 06/18/24 Vancomycin HCl intravenous solution 1500 mg/15 ml every 12 hours for Osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection). -Order Date: 06/24/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. -Order Date: 06/27/24 Vancomycin HCl intravenous solution 1750 mg/350 ml every 12 hours for infection to right knee. Interview and Record Review of electronic Nurses Progress Notes on 07/12/24 at 3:01 PM with the ADON for Resident #3 revealed IV antibiotic was not administered according to physician's orders due to lab results not received on time when the Vancomycin was scheduled to be administered and/or pending delivery from the pharmacy. ADON stated, That is why we are changing labs, because labs were not done on a timely basis or lab results were not received on a timely basis. The ADON confirmed that the facility did not have any written documentation in Resident #3's electronic Nurses Notes that documented physician was notified medication was not administered as ordered due to not having labs not done on a timely basis and/or not receiving lab results on a timely basis to determine the dosage for the next medication administration. ADON reported Nurses had been trained to immediately notify the attending physician/NP/DON/ADON if medications were not administered as ordered and to document the notification in the Nurse's Progress Notes. The MAR revealed: -06/11/24 at 8:08 PM written by LVN F, revealed, pending delivery from pharmacy, couldn't send until the [sic] had result of the Vanco trough. -06/21/24 at 3:13 PM, written by LVN F revealed, writer obtained results of Vanco trough that was drawn during previous shift and faxed them to the pharmacy twice. Pharmacy employee stated to ADON for the 300 hall [sic] that the results had not been received, when ADON asked if she could provide a verbal result, pharmacy employee stated she (ADON) would have to be transferred to the IV department. ADON did not receive an answer but left a message for an individual in the IV department named [NAME]. Results were faxed a third time by the ADON, pending response. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Grievance/Complaint Report dated 06/26/24 for Resident #3 written by the Social Worker revealed, Documentation of Grievance/Complaint related to Nursing Care. The resident stated that nursing staff were inconsistent with providing her antibiotics. Summary/Findings written by the DON on 06/26/24 revealed the medication required labs prior to every 3rd dose. The medication may change depending on lab results. Recommendations/Action Taken continue to draw labs as ordered and give the medication. Resolution of Grievance/Complaint Was grievance/complaint resolved? No. Family feels the facility should give medication at 8 AM and 8 PM regardless. Identify the method(s) used to notify the resident and/or representative of the resolution: Phone conversation. In an interview 07/09/24 at 3:59 PM, LVN F reported Resident #3 was at the facility for a very short stay and was discharged back home. The resident was alert and oriented to person, time, place, she was admitted for IV antibiotics, status post-surgery to right knee, due to the hardware got infected. LVN F stated, We had issues with the lab not sending the trough level results on a timely basis, which delayed timely delivery of the IV antibiotic. The resident also went out on frequent 4 hours passes with her family. The family member was very upset because the resident had missed the morning dose of the IV antibiotic. The family could not understand that the blood work needed to be done prior to administering the next dose of the IV medication so the dosage could be adjusted as need and could not understand that they could not double up on missed doses, because the medication was very toxic to the kidneys. LVN F stated the DON and ADON were aware that they were having problems with the lab provider not coming to draw blood as ordered and/or lab results were not sent to facility on a timely basis and resulted in residents not getting prescribed antibiotics as ordered. Telephone interview on 07/10/24 at 8:50 AM, with the attending physician for Resident #3 revealed, that he expected the licensed staff to report to physician and/or NP if the prescribed medication had not been administered as ordered due to the lab not coming to draw blood for ordered labs and/or not sending lab results on a timely basis to determine Vancomycin IV can be administered as ordered. The Physician stated that licensed staff cannot order labs without a physician's order. The physician stated The licensed staff should immediately notify physician and/or the NP of a change in condition at which time a decision will be made if labs will need to be ordered, depending on the resident's change in condition. It is very important that labs results are obtained as soon as possible to ensure that medical treatment is not delayed. Interview and record review on 07/12/24 at 2:53 PM, the Social Worker revealed she had talked to Resident #3 about her not getting her prescribed antibiotic as ordered. The Social Worker stated, I do not know why she was not getting her medication as ordered. Interview and record review of the electronic Nurses Progress Notes at 07/12/24 at 3:01 PM with the ADON for Resident #3 revealed IV antibiotic was not administered according to physician's orders due to lab results not received on time when the Vancomycin was scheduled to be administered and/or pending delivery from the pharmacy. ADON stated, That is why we are changing labs, because labs were not done on a timely basis or lab results were not received on a timely basis. The ADON confirmed that the facility did not have any written documentation in Resident #3's electronic Nurses Notes that documented physician was notified medication was not administered as ordered due to not having labs not done on a timely basis and/or not receiving lab results on a timely basis to determine the dosage for the next medication administration. ADON reported Nurses had been trained to immediately notify the attending physician/NP/DON/ADON if medications were not administered as ordered and to document the notification in the Nurse's Progress Notes. (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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed: -06/11/24 at 8:08 PM written by LVN F, revealed pending delivery from pharmacy. The pharmacy could not dispense the medication until the facility sent the result of the vanco trough to the pharmacy. -06/21/24 at 3:13 PM, written by LVN F revealed the writer obtained results of Vanco trough that was drawn during previous shift and faxed them to the pharmacy twice. Pharmacy employee stated to ADON for the 300 hall that the results had not been received. When ADON asked if she could provide a verbal result the pharmacy employee stated she (ADON) would have to be transferred to the IV department. The ADON did not receive an answer but left a message for an individual at the pharmacy. Results were faxed a third time by the ADON, pending response. In an interview and record review 07/09/24 at 8:43 AM, with LVN J revealed that a lot of the times the lab provider did not send test results on a timely basis and the nurses would report that to the DON. LVN J reported that not getting lab results on a timely basis delayed the start of treatment. Confidential interview on 07/11/24 at 11:01 AM, revealed Resident #2 had a physician order for Clindamycin IV to treat a UTI. The medication was not given as ordered because the medication was not delivered by the pharmacy and the medication was not on hand in the Emergency Kit. It was reported that the lab did not come on a timely basis to draw blood for the ordered labs and the IV medication could not be administered until labs have been done and results have been received and reported to physician. Interview 07/10/24 at 2:11 PM, with the Administrator revealed he had started to work at the facility on May 13, 2024. The Administrator stated he was informed by the DON upon hire, that the facility was having a lot of problems with the current lab provider not drawing or collecting specimens on a timely basis and/or lab results were not sent on a timely basis delaying medical treatment. The Administrator reported they were in the process of changing lab providers and signing of the lab provider contract was pending. The Surveyor requested policy & procedure of Laboratory Services. No policy was brought forth prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20026 Based on interview and record review, the facility failed to ensure medical records were maintained on each resident that were complete and accurately documented for 2 of 6 (Resident #1, and Resident #2) reviewed for accuracy and completeness of medical records. -The facility failed to document notification of change of condition for Resident #2 on 07/03/24. -The facility failed to ensure SBAR INTERACT Communication Form for Resident #1 did not have blanks in the documentation. -The facility failed to document in Event Report for Resident #1 injuries and mental status at time of incident on 06/22/24. -The facility failed to document an order for use of grab bars for Resident #1. -The facility failed to document for Resident #1 the type of pain and pain medication that was administered. -The facility failed to ensure Pain Evaluation dated 06/26/24 for Resident #1, was signed and dated. -The facility failed to ensure the Pain Evaluation dated 07/12/24 for Resident #1 did not have blanks in the documentation. -The facility failed to document the attending physician was notified the IV antibiotic for Resident #2 was not administered as ordered. -The facility failed to document pain medication was administered to Resident #2 according to physician's orders. These failures could place residents at risk of not receiving needed services. Findings included: Resident #1 Review of the Admission Record dated 07/08/24 at 5:31 PM revealed, Resident #1 was initially admitted on [DATE] and readmitted [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Hospital History & Physical dated 06/23/24 for Resident #1 revealed, Chief Complaint: Right Hip Fracture. [AGE] year-old-female with PMH (past medical history) of DM II (insulin dependent), recurrent UTI, dementia, hypertension was brought to our hospital due to fall. Patient had an accidental mechanical fall 2 days ago from her bed, when she rolled from her bed. Her left hand was caught in the handrail and landed on her left lower limb. She was able to move well after the fall, no head strike/LOC. She had complained of generalized pain/was fatigued during the next day. Hence, after discussion with her PCP, plan was to prescribe pain medication for her pain, but facility's pharmacy not opened at this time and hence was transferred to the hospital for pain management. Patient was still able to perform her ADLs by herself, but with pain. Baseline: She is wheelchair bound, able to transfer from bed to the chair and commode herself. She is still able to do so after the fall. Medical History: Acute UTI, Anxiety, Dementia, Lower back pain, osteoporosis, PVD (peripheral vascular disease). Review of the Quarterly MDS dated [DATE] for Resident #1 revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMS Score 06, (severely impaired), no behavior symptoms, wheelchair, ADLs-partial/moderate assistance with toileting hygiene, upper body dressing, hygiene; Functional Abilities: Requires partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed; substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer; always incontinent of urine; frequently incontinent of bowel. Review of the Care Plan Date initiated 02/09/24 and revised 02/10/21 for Resident #1 revealed, I have Cognitive Impairment r/t dementia, episodes of disorganized thinking, episodes of inattention, and Impaired Safety Awareness. Revised 06/26/24 Risk for injury r/t history of falls and is at risk for further falls r/t noncompliance with safety interventions, cognitive impairment, impaired safety awareness, incontinence urgency, gait/balance impairment. Interventions: 02/03/22 Will keep closer to nurses' station for closer supervision. 08/25/23 Continue with bed to lowest position with floor mat next to bed. Instruct resident to call for help before getting out of bed or chair, always keep call light in reach. Provide toileting assistance per rounds and PRN. Date initiated 02/09/21; Revised 02/10/21 I require assist with ADLs transfers and toilet use. Approaches: Date initiated: 02/10/23; Revised 07/07/23. Bed Mobility: independent I use the quarter enablers to assist me in bed for reposition and transfers. Date initiated: 08/31/23. May use T-bar for bed positioning. Transfer, limited assistance x 1 person, uses quarter enablers to assist in support for transfers. Review of Physician Order Summary Report dated 07/08/24 at 5:28 PM for Resident #1 revealed, Order Date Range: 04/01/24 - 07/31/24. Order date: 06/22/24 X-ray to lower back, hips, pelvis, and left arm. Order date: 06/22/24 cleanse skin tear on left forearm with normal saline, pat dry, and apply steri-strips, apply dressing and secure with tape daily until healed. Order date: 06/25/24 at 9:00 PM Oxycodone HCl give 2.5 ml via G-Tube every 6 hours as needed for moderate to severe pain. Order date: Plavix 75 mg give 1 tablet via G-tube once a day for peripheral vascular disease. Order date: 04/18/24 Enteral Feeding Order every shift with Diabetic Source 1.2 at 45 ml/hr. with water flush 120 m/4 hrs. was discontinued on 06/27/24. Order date: 07/06/24 Enteral Feeding Order every shift for adequate nutrition Glucerna 1.2 at 45 ml/hr. with water flush 140 ml/hr. The Physician Order Summary did not reflect an order for use of grab bars. Record review of Physician Order Summary Report dated 07/08/24 at 5:28 PM for Resident #1 revealed, Order Date Range: 04/01/24 - 07/31/24 did not document an order for use of grab bars. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the SBAR INTERACT form dated 06/22/24 written by LVN B at 2:19 AM, for Resident #1 revealed, The Change of Condition: Fall. Primary Diagnosis is Urinary Tract Infection. Outcome of Physical Assessment: Mental Status Evaluation: No changes observed. Functional Status Evaluation: Fall. Skin Status Evaluation: Skin Tear. Pain Status Evaluation: was left blank. Review of the SBAR Communication Form dated 06/22/24 completed by LVN B for Resident #1 revealed, The change in condition: Fall. Since this started it has gotten: Stayed the same. Functional Status Evaluation (compared to baseline; check all that you observe) Falls (one or more); Skin Evaluation: Skin Tear. Pain Evaluation: Not clinically applicable to the change in condition being reported. Review and Notify: Primary Care Clinician Notified: Yes Date: 06/22/24 at 6:00 AM. b. Check all that apply: Testing checked-Other (describe) was left blank. Interventions: Other (describe) was left blank. Review of Event Report dated 06/22/24 written by LVN B for Resident #1 revealed, nurse did not document injuries observed at time of incident and mental status. Review of the Pain Evaluation dated 06/26/24 for Resident #1 revealed PAINAD Score: 0 (The Pain Assessment in Advanced Dementia is a tool used to assess pain in patients with dementia and other illnesses). Pain Category was left blank. A. Pain Evaluation 1a. Does the resident have any diagnosis which would give reason to believe he/she would be in pain? Yes. 1b. If yes, describe cause, origin of pain, radiation of pain, and prior treatment: Was left blank. D. Pain Intensity Numeric Rating Scale (00-10) was left blank. Assessment was not signed or dated by the nurse that completed the assessment. Review of the Pain Evaluation dated 07/12/24 for Resident #1 revealed PAINAD Score: 2. Pain Category was left blank. A. Pain Evaluation 1a. Does the resident have any diagnosis which would give reason to believe he/she would be in pain? Yes. If yes, describe cause, origin of pain, radiation of pain, and prior treatment: Wrist Fracture. Numeric Rating Scale (00-10) 07. The assessment was signed by ADON. Interview and record review 07/12/24 at 10:22 AM with the ADON, revealed that the facility did not have any documentation of the meeting that was held with the Resident #1's family member and the Ombudsman. The ADON stated, I call the DON, and she said that she had not written a note in the resident's electronic record, because the Ombudsman's visit was not a formal meeting. Interview and record review 07/12/24 at 10:50 AM with the ADON, revealed LVN B had not documented that Resident #1 had sustained a skin tear to left arm and had a fractured her left wrist on 06/22/24 in the resident's electronic record. The nurses have been trained to immediately document changes in condition in the electronic records. Resident #2 Review of the Admission Record dated 07/08/24 at 5:30 PM revealed Resident #2 was initially admitted on [DATE] and readmitted [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Annual History & Physical dated 08/01/23 for Resident #2 revealed [AGE] year-old female with diagnoses of hypertension, dementia, anxiety, epilepsy, hyponatremia (a condition that occurs when the level of sodium in the blood is too low), stenosis of peripheral vascular stent (a stent is a permanent device that's inserted to keep blood flowing) stable (stenosis is a narrowing of the arteries in the legs and feet, malignant epithelial neoplasm of vulva (a cancer of the external genitals), encephalopathy (is a serious neurological condition that occurs when the brain is damaged or diseased causing brain function to change). Alert, oriented to person. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #2, revealed hearing adequate, clear speech, usually understood, usually understands others, vision impaired, BIMs Score 05, (severely impaired cognition), no behavior symptoms, wheelchair, ADLs-toileting supervision or touching assistance; extensive to moderate assistance with sit to lying, sit to stand, chair/bed transfer, shower transfer; always incontinent of bowel & bladder; active diagnoses-heart failure, hyponatremia, non-Alzheimer's dementia, epilepsy, depression, encephalopathy; repeated falls; no pain; medications-antianxiety, antidepressant, and hypnotic. Review of the Care Plan revised 06/27/23 for Resident #2 revealed the resident was at Risk for UTIs (Urinary Tract Infection) r/t incontinent of bowel & bladder due to poor cognition. Interventions: Administer meds per MD order. In an interview and record review 07/09/24 at 8:43 AM, with LVN J, revealed that the last week on 07/03/24, he was checking Resident #2's vital signs, and had noted Resident #2 had an irregular pulse, and had reported this to the attending physician and an order was given for a stat (immediately) EKG (electrocardiogram is a test to record the electrical signals in the heart). LVN J reported the EKG and was still pending to be done at the change of shift and he had notified the on-coming nurse at the change of shift and had not documented this in the resident's electronic Nurses Progress Notes. LVN J stated, I notified Nurse Practitioner on 07/09/24 via text message of the new order and I did not document the notification in the resident's electronic record. LVN J reported licensed staff had been trained to document changes in condition and notifications in the resident's electronic progress notes. The Surveyor requested a screen shot of text message. Review of a text message sent to the surveyor on 07/09/24 at 9:22 AM, by LVN J revealed a copy of x-ray report was attached to text message sent to the NP. The text message reflected Ok, thanks. Do you want to refer to cardio? No, I don't think the [family member] would agree. Interview and record review on 07/09/24 at 9:10 AM, with LVN J revealed he had not documented the change in condition and physician and family notification in the resident #2's electronic nurse's progress notes. LVN J stated, I know that I wrote a note in the electronic progress notes but can't find it. LVN J reported that they had been trained to complete SBAR Communication Form Interact Tool for changes in condition that included notification of the physician and family. LVN J reported that he had notified the Nurse Practitioner (NP) on 07/04/24 via text message of the new orders and had not documented the notification in the resident's electronic Nurse's Progress Notes. LVN J stated the NP had responded back to the text message and had not given any orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	07/27/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 07/09/24 at 9:12 with the DON, in the presence of LVN J confirmed he had not documented in the Resident #2's clinical record on 07/03/24 the change in condition and notification to the physician and responsible party. The DON stated, The licensed staff had been trained to complete SBAR Communication Form Interact Tool for changes in condition that includes notification of physician and family. Review of the electronic Nurses Progress Notes for Resident #2 revealed: -06/14/24 at 9:41 PM INTERACT SBAR Summary form (provides a framework for communication between health care team about a patient's condition) written by LVN D reflected Clindamycin 300 mg IV 3 x a day for 7 days for UTI. -06/15/24 at 12:59 PM note written by LVN E reflected, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available. -06/15/24 at 5:39 PM note written by LVN E reflected, Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. -06/15/24 at 7:27 PM note written by LVN E reflected Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) three times a day x 7 days. Not available, pending pharmacy delivery. Review of the Medication Administration Record (MAR) dated June 2024 for Resident #2 revealed: -Order Date: 06/14/24 for Clindamycin Phosphate 300-0.9 mg/50 ml in sodium chloride solution intravenously three times a day for UTI for 7 days. The MAR reflected the medication was not administered on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. IV Clindamycin Phosphate was discontinued on 06/17/24 and was changed on 06/17/24 to Clindamycin HCL 300 mg give 1 capsule by mouth three times a day for UTI x 10 days. Record review revealed the facility did not have written documentation in Resident #2's electronic Nurses Progress Notes that reflected the attending physician and/or NP were notified Clindamycin Phosphate in NaCl (Sodium Chloride) intravenous solution 300-0.9 mg/50 ml (milliliter) was not available to administer according to physician's order on 06/15/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/16/24 at 8:00 AM, 2:00 PM and 8:00 PM; 06/17/24 at 8:00 AM. Review of the Medication Administration Record (MAR) dated June 2024 for Resident #2 revealed: MAR did not document Acetaminophen 500 mg give 2 tabs by mouth every 8 hours as needed for pain was administered by LVN D, when resident complained of pain on 06/06/24 Pain Level was at a 3; 06/07/24 Pain Level was at a 2; 06/12/24 Pain Level was at a 4; 06/13/24 Pain Level was at a 4; 06/17/24 Pain Level was at a 1; 06/19/24 Pain Level was at a 2; 06/20/24 Pain Level was at a 2; 06/25/24 Pain Level was at a 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	07/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review 07/10/24 at 7:35 AM, the DON stated, It took 3 days for the nurses to call the physician for Resident #2 and report that Clindamycin IV had not been given as ordered and to change the Clindamycin from IV to PO. There is no excuse. The nurses should have notified the physician or the NP right away to let them know that the pharmacy had not delivered the Clindamycin IV as ordered. The nurses have been trained to immediately notify the physician and NP if the medications are not in the E-Kit or if the pharmacy has not delivered the prescribe medication to administer as ordered. The nurses have been trained to document this in the resident's clinical records. I do not know why the nurses failed to document in the resident's clinical record. Interview and record review on 07/12/24 at 3:19 PM, with LVN D on the 2-10 shift revealed, she had documented on the MAR dated June 2024, that Resident #2 had pain on the following days: 06/06/24 Pain Level was at a 3; 06/07/24 Pain Level was at a 2; 06/12/24 Pain Level was at a 4; 06/13/24 Pain Level was at a 4; 06/17/24 Pain Level was at a 1; 06/19/24 Pain Level was at a 2; 06/20/24 Pain Level was at a 2; 06/25/24 Pain Level was at a 1. LVN D stated, I did not document in the electronic progress notes, what type of pain the resident was having, and I did not document in the electronic progress notes or on the medication administration record if I medicated the resident with Acetaminophen as needed for pain according to physician's orders. LVN D reported they had been trained to document their assessment in the resident's electronic progress notes and on the MAR if pain medication was administered. The LVN D stated they were also trained to follow up if the pain medication was effective. Surveyor requested policy & procedure on documentation in Resident's clinical record. No information was brought forth prior to exit.