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	11/08/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review the facility failed to immediately notify and consult with the resident's physician and resident's representative when a significant change in a resident physical, mental, or psychosocial status (that was a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #2) of 4 residents reviewed for change in condition. The facility failed to immediately inform the NP/MD and the family (RP/POA) on 09/24/24 of Resident #2's change in condition addressing her fall on 09/24/24. This failure could place residents at risk of serious decrease in health related to delayed treatment. Findings included: Record review of Resident #2's face sheet dated 11/05/24, revealed, admission on 05/09/24 and re-admission on 06/27/24 to the facility. Record review of Resident #2's facility history and physical dated 11/03/24, revealed, an [AGE] year-old female diagnosed with Dementia and falls. Record review of Resident #2's quarterly MDS dated [DATE], revealed, a severely impairment in cognition BIMS score of 6 to be able to recall and make daily decisions. Resident #2's ADLs revealed, to be coded for Substantial/maximal assistance for personal hygiene, toileting, and shower/bath, partial/moderate assistance (facility staff does less than half the work). Resident #2's functional abilities was coded for substantial/maximal assistance (facility staff do more than half of the work) for roll left and right in bed, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer. Resident #2 was diagnosed with difficultly in walking, muscle weakness (when you have difficulty moving your muscles normally, even when you try your best), muscle wasting (the loss of muscle mass and strength), and atherosclerosis native arteries of the extremities (disease that causes the arteries that supple the legs and feet to narrow and harden). (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan dated 05/21/24, revealed, Resident #2 had a history of falls related to self-transfer without assistance and had balance issues during transition. Increased frequency of rounds, educate about safety reminders and what to do if a fall occurs, follow facility fall protocol, keep bed to lowest position, resident to have mat on floor beside bed when bed was occupied, and attempt to determine cause of falls. Record review of Resident #2's Fall Risk assessment dated [DATE], revealed, a score of 13 being High Risk for falls. History of Falls in the pasted 3 months was coded for 102 falls in pasted 3 months. Record review of Resident #2's Fall Risk assessment dated [DATE], revealed, a score of 5 and did not indicate the level of Risk for falls on the scale. History of Falls in the pasted 3 months was coded as 0 - No falls in past 3 months. Record review of Resident #2's Progress Notes created by LVN A dated 09/26/24, revealed, On 09/24/24, Resident #2 was found on the floor mat. Resident #2 stated she wanted to turn off the TV and forgot to ask for help. Resident #2 was assessed and neuro checks - WNL, full ROM x4 extremities with no pain. Resident #2 assisted back to bed. No s/s of injury noted. Record review of Physician R's text message from LVN A dated 09/26/24 at 1:19 PM, revealed, LVN A - Hi, Tuesday night (09/24/24) after you (Physician R) left. Resident #2 fell out of bed on the floor mat. I forgot to text you but no injuries. [NAME] checks wnl. No Pain. During an interview on 10/19/24 at 3:01 PM, with the family member and Resident #2. The family member stated, she came into the facility on [DATE] to see Resident #2. The family member stated Resident #2 was complaining that her butt was hurting and asked why. The family member stated Resident #2 had remembered she had a fallen the previous day (09/24/24). The family member stated she asked CNA T if Resident #2 had a fallen and CNA T told her she did have a fall on 09/24/24. The family member stated she was unaware of any fall and was not notified of a fall for Resident #2 as she was the RP/POA for Resident #2. The family member stated MDS Coordinator F was asked if Resident #2 had fallen and wanted to see the incident report. The family member stated the DON and MDS Coordinator F did not see any report for the fall. The family member stated she conducted her own investigation into what had happened. The family member stated the DON had written up LVN A for failure to notify her of the fall incident for Resident #2. The family member stated she had wrote her own questions that she wanted to ask LVN A with the approval of the DON in a meeting. The family member stated the facility approved the meeting with the questions. The family member stated LVN A commented that she was busy and there was a lot going on that night that she had forgot to make the notification to her. Resident #2 remained quiet and did not answer any questions, only looked at state agency. During an interview on 10/24/24 at 1:51 PM, with LVN E, she stated Resident #2 had a fall but not on her shift. LVN E stated Family member was upset because she had not heard about the fall right away. LVN E stated LVN F told her that Resident #2' family wanted to know what had happened with Resident #2 on 09/24/24. LVN E stated anytime there was an incident with a resident the family members and physician were to be notified. LVN E stated they were to be notified because they need to be made aware of what was going on with the resident. LVN E stated the risk would depend on the resident's incident situation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 2:10 PM, with LVN A, she stated she was working the day of the incident and Resident #2 was one of her residents. LVN A stated she normally does not worked hall 200 and was working a double shift (6AM-10PM) on 09/24/24. LVN A stated she was overwhelmed and busy. LVN A stated Resident #2 did have a fall and did forget to call the family member. LVN A stated she did notify the physician of the incident that night on 09/24/24. LVN A stated the family was notified the next day on 09/25/24 of the fall Resident #2 had. LVN A stated she assessed Resident #2 and started neurological checks and Resident #2 was fine. LVN A stated she was counseled by the DON and re-educated on notifications to family. LVN A stated that the family wanted to have a meeting with her and the DON regarding the notification and other questions the family had about the incident. LVN A stated the negative outcome of not notifying the family would depend on the situation the resident was in. On 10/24/24 at 2:29 PM, Physician R was called but there was no answer, and a text message was sent to call back state agency due to not being able to leave voice message. On 10/25/24 at 11:03 AM - Physician R was called and was forwarded to automated message system. Voice message was left, and another text message sent to call back state agency. During an interview on 10/25/24 at 1:01 PM, with the DON, she stated LVN A had picked a shift on 09/24/24. The DON stated Resident #2 slid out of bed. The DON stated LVN A called the physician but not the family. The DON stated LVN A was written up and counseled for failure to made notifications. The DON stated Resident #2 had no injuries. During an interview on 10/25/24 at 11:32 AM, with MDS Coordinator F, he stated the family member had asked him if Resident #2 had fallen on 09/24/24. MDS Coordinator F stated he was not working the floor and did not know but would check. MDS Coordinator F stated he did not see anything documented in the progress notes for a fall and directed her to the DON for further information. MDS Coordinator stated it was expected for nursing staff to be notifying the family and the physician anytime a resident had a incident. MDS Coordinator F stated he could not answer if there would be a negative outcome because he was not there to assess the situation. On 10/28/24 at 9:52 AM, CNA T was called, and a voice message and text message were sent/left to call back state agency. During an interview on 10/28/24 at 2:40 PM, with CNA T, she stated she was working the day (09/24/24) of the incident in which Resident #2 had a fall. CNA T stated she was coming back from back and passing by Resident #2's room and saw Resident #2 on the ground on her rear with her back leaning on her bed. CNA T stated she reported it to LVN A and did not know if she had notified the family or physician. CNA T stated the following day (09/25/24) when she was assisting in toileting Resident #2 the family member asked her if Resident #2 had fallen. CNA T stated the family member had told her she was not informed of the fall. During an interview on 10/29/24 at 1:17 PM, with Physician R, he stated he was informed of the incident with Resident #2 who had a fall on 09/24/24, 48 hours later on 09/26/24. The Physician R stated it was expected of the facility to notify him of the incident when it happens. Physician R stated LVN A had told him via text message that Resident #2 had a fall and was fine on 09/24/24. Physician R stated there could have been a negative outcome of not notifying him which would depend on the situation and condition at the time of the incident for Resident #2, in case she was fine. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/24 at 8:52 AM, with the DON, she stated Resident #2 had an unwitnessed fall on 09/24/24. The DON stated Resident #2 was found on the ground on her fall mat sitting down on her rear. The DON stated it was facility policy that the physician will be notified of a change in condition. The DON stated LVN A had contacted the physician that night. The DON stated the risk would depend on if the resident had sustained any injuries but she was fine. Record review of the facility Notification of Changes dated 02/2003, revealed, Policy: The purpose of this policy was to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there was a change requiring notification. Record review of the facility Grievance/Complaint Report dated 09/27/24, revealed, A grievance/complaint related to nursing care for LVN A for failing to call family on 09/24/24 of a fall for Resident #1 incident. DON conducted an investigation on 09/26/24, with findings of LVN A who did forget to call the family. Recommendations/Action taken was to re-educate LVN A on CIC and notifications of RP. Resolution of Grievance/Complaint was coded as grievance/complaint report not being resolved - Family felt that LVN A should have called her. Record review of LVN A's Corrective Action Notice dated 09/24/24, revealed, Specific Reason for Corrective Action (Rule violated, Unacceptable Action or performance shortcoming): Not contacting family of fall. The following improvements are required immediately (what the employee must do to correct the problem(s). Including time frames.): Follow policy, call all parties. Employee Comments: I forgot to call because I got busy.

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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** 46998 Based on observation, interviews and record reviews, the facility failed to ensure that the assessment accurately reflected the resident's status for 3 (Resident #5, Resident #9, and Resident #10) of 10 resident reviewed for accuracy of MDS assessment, in that: Resident #5's quarterly MDS did not accurately reflect the residents' oxygen therapy in the quarterly MDS assessment. Resident #9's quarterly MDS did not accurately reflect the residents' oxygen therapy in the in the quarterly MDS assessment. Resident #10's quarterly MDS did not accurately reflect the residents' oxygen therapy in the in the quarterly MDS assessment. This failure could affect residents at the facility who had been assessed for oxygen therapy use and could contribute to inadequate care. Findings included: Resident #5 Record review of Resident #5's face sheet dated 11/05/24, revealed, admission on 09/11/24 to the facility. Resident #5's profile picture had Resident #5 wearing his nasal cannula. Record review of Resident #5's facility history and physical dated 09/17/24, revealed, an 89year-old female diagnosed with COPD and history of tobacco smoking. Record review of Resident #5's admission MDS dated [DATE], revealed, a moderately cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #5 was diagnosed with respiratory failure and one of the following asthma, COPD, or Chronic Lung disease. Resident was not coded for oxygen therapy. Record review of Resident #5's orders reviewed on 10/22/24, revealed, no orders for oxygen therapy. Record review of Resident #5's baseline care plan dated 09/17/24, revealed, coded for oxygen therapy. Observation on 10/23/24 at 3:04 PM, revealed, Resident #5 in bed with his nasal cannula on and concentrator on. Oxygen tank was seen behind Resident #5's wheelchair. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/28/24 at 3:59 PM, with Resident #5, revealed, Resident #5 to have his nasal cannula on while in the dining room. Resident #5's oxygen tank was placed behind his wheelchair reading empty with arrow on white mark on tank. Resident #5 was not coughing nor struggling to breath. Resident #5 stated he did not know his oxygen tank was out. Resident #5 stated it needed to be changed. Resident #5 stated he was okay. Resident #9 Record review of Resident #9's face sheet dated 11/05/24, revealed, admission on 02/23/23 and re-admission on 08/05/24 to the facility. Record review of Resident #9's facility history and physical dated 09/19/24, revealed a [AGE] year-old male diagnosed with COPD and chronic hypoxia respiratory failure. Record review of Resident #9's 5-day MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 3 to be able to recall information or make daily decisions. Resident #9 was diagnosed with asthma and respiratory failure, chronic respiratory failure with hypoxia. Resident was not coded for oxygen therapy. Record review of Resident #9's care plan dated 08/22/24, revealed, at risk of respiratory infections/distress, hypoxia, shortness of breath, and cough related to COPD. Administrator medications as ordered. Administrator oxygen as ordered. Record review of Resident #9's orders dated 08/08/24, revealed, oxygen at 2 liters per minute via nasal cannula to maintain saturation level greater than 90percent related to asthma and COPD (a common lung disease that makes it difficult to breathe). Observation and interview on 10/28/24 at 3:59 PM, with Resident #9 revealed Resident #9 had her nasal cannula on in the dining room. Oxygen tank behind her wheelchair read empty with arrow pointing on white. Resident #9 was not struggling to breathe nor coughing or wheezing for air. Resident #9 shook her heading indicating she was fine when asked if she was okay and able to breathe. Resident #10 Record review of Resident #10's face sheet dated 11/05/24, revealed, admission on 02/01/21 and re-admission on 07/18/24 to the facility. Record review of Resident #10's facility history and physical dated 02/05/21 provided by the ADON, revealed, an [AGE] year-old female (actual age in 2024 - [AGE] year-old) diagnosed with Alzheimer and Diabetes Mellitus (chronic disease that occurs when the body cannot regulate blood sugar levels). Record review of Resident #10's quarterly MDS dated [DATE], revealed, a severely impaired cognitive BIMS score of 5 to be able to recall or make daily decisions. Resident #10 was diagnosed with Non-Alzheimer's Dementia, Alzheimer's Disease, and muscle wasting. Resident #10 was not coded for oxygen therapy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's orders dated 08/23/22, revealed, oxygen at 2-3 liter per minute via nasal cannula as needed for any s/s of Shortness of Breath and dyspnea (the frightening sensation of being unable to breathe normally or feeling suffocated). Record review of Resident #10's care plan dated 11/05/24, revealed, impaired gas exchange related to lung consolidation (bringing together some large number of items into a single, smaller number) related to pneumonia (infection of one or both of the lungs to fill with fluid or pus, making it difficult to breath). Administer oxygen as ordered: none ordered at this time. Monitor oxygen saturation through pulse oximetry every shift as needed, maintaining oxygen saturation of 90 percent or greater. Observation and interview on 10/25/24 at 9:53 AM, with Resident #10, revealed, she was in room wearing a nasal cannula with her oxygen tank behind her wheelchair on empty with the arrow reading white. Resident #10 stated she was fine. Resident #10 did was not wheezing, coughing, or struggling for air. During an interview on 11/06/24 at 1:06 PM, with MDS Coordinator F and MDS Coordinator V. MDS Coordinator F stated the MDS Department was responsible for the MDSs that were generated and conducted. MDS Coordinator F stated if a resident was on oxygen such as Resident #5, Resident #9, and Resident #10, then it would have to be coded in the MDS for oxygen therapy. MDS Coordinator F stated MDS department was responsible for ensuring they were accurate. MDS Coordinator V stated the negative outcome would be for reimbursement purposes. MDS Coordinator F stated that the reimbursement would be lower. Record review of the facility Maintaining Minimum Data Set (MDS) Assessments policy dated 07/22, revealed, Policy: The facility will maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This policy does not specify accuracy of MDS assessments. Record review of the facility Resident Assessment - RAI dated 07/22, revealed, Policy: This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI_ specified by CMS. The assessment will include at least the following: Medications and Special treatments and procedure.

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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** 46998 Based on observation, interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 2 of 10 residents (Resident #4 and Resident #7) reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan for Resident #4's history of oxygen therapy. The facility failed to implement a comprehensive person-centered care plan for Resident #7's history of oxygen therapy. This failure could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings include: Resident #4 Record review of Resident #4's face sheet dated 11/05/24, revealed, admission on 02/29/24 and re-admission on 04/29/24 to the facility. Record review of Resident #4's facility history and physical dated 03/06/24, revealed, a [AGE] year-old female diagnosed with dysarthria (difficulty speaking clearly due to muscles used to speak are weak or not working properly.) and weakness. Record review of Resident #4's annual MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 5 to be able to make daily decisions and recall information. Resident #4 was coded for oxygen therapy. Record review of Resident #4's orders dated 05/06/24, revealed, oxygen at 4 liter per minute via nasal cannula continuous. May remove for ADLs. Record review of Resident #4's care plan reviewed on 11/05/24 revealed there was no care plan for oxygen therapy. Observation and interview on 10/24/24 at 1:32 PM, with Resident #4. Resident #4 was in bed with nasal cannula on. Resident #4 stated she does use her wheelchair and had used it prior to being in bed that day. Resident #4 stated nursing staff do change out her oxygen tank. Resident #4's oxygen tank was placed behind her wheelchair. The oxygen tank read empty. Resident #4 stated she had just sat in her wheelchair earlier but could not remember if there was oxygen coming out or not. Resident #7 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's face sheet dated 11/05/24 revealed an [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, pneumonia, dysphagia, and dementia. Record review of Resident #7's facility history and physical dated 10/16/24, revealed, a [AGE] year-old female diagnosed with history of pulmonary Embolism (a life-threatening blockage in an artery in the lung that occurs when a blood clot breaks loose and travels through the bloodstream). Record review of Resident #7's admission MDS dated [DATE] revealed a BIMS score of 15, her cognition was intact and was coded for receiving oxygen therapy. Record review of Resident #7's care plan dated 11/05/24, revealed, no focus area for oxygen therapy. Record review of Resident #7's orders dated 10/25/24 revealed order for oxygen therapy at 2 LPM via nasal cannula. Observation on 10/24/24 at 1:32 PM, revealed, Resident #7 to be in bed with the nasal cannula on and concentrator running. During an interview on 11/06/24 at 1:06 PM, with MDS Coordinator F and MDS Coordinator V. MDS Coordinator F stated the MDS Department was responsible for the care plans. MDS Coordinator V stated the purpose of a care plan was to address the needs and services that the nurses will do for a resident. MDS Coordinator F stated the negative outcome of not care planning the oxygen therapy for a resident would be someone not knowing to give oxygen to a resident. Record review of the facility Comprehensive Care Plan(s) policy not dated, revealed, Policy: It was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review, the facility failed to ensure that services provided or arranged by the facility met professional standards of quality for 1 of 8 (Resident #1) residents reviewed for care, in that: The facility failed to provide care that included but not limited to assessing, evaluating, and responding to residents needs for Resident #1. On [DATE], LVN D did not conduct a thorough assessment of Resident #1 when informed by CNA C that Resident #1's family informed her the resident had stopped talking while eating and spit out a piece of meat. LVN D did not have her stethoscope to check lung sounds. LVN D, when the family requested 911 be called, responded that they (the family) could call 911 if they wanted. LVN D did not go back to re-assess Resident #1 to determine if the resident needed the Heimlich maneuver, or stay with the resident to observe her eating to determine if there was a problem with her eating or swallowing. The family contacted 911, and EMS took Resident #1 to the hospital where she was intubated, and expired on [DATE]. An IJ (immediate jeopardy) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:15 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of potential for more than minimal harm at a scope of isolated because all staff had not been trained on reporting changes in condition. This failure placed Residents at risk for abuse and neglect. Findings included: Record review of Resident #1 ' s face sheet dated [DATE], revealed, an [AGE] year-old female admitted on [DATE], diagnosed with Muscle weakness, Acute Respiratory failure with Hypoxia (not enough oxygen in the blood) she was a full code status. Record review of Resident #1 ' s quarterly MDS dated [DATE], revealed ADLs for feeding to be Independent to setup or clean up assistance. Resident #1 ' s BIMS score was a 15 score, indicating no cognitive impairment. There was no indication of swallowing issues. Record review of Resident #1 ' s physician order dated [DATE] revealed no concentrated sweets, diet regular texture, thin consistency. Record review of Resident #1 ' s Nutrition Risk assessment dated [DATE], revealed Regular Diet and Thin liquids. (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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1 ' care plan dated [DATE] revealed focus area of receiving a therapeutic or altered consitency diet and it at risk for nutritional impairment with no concentrated sweets, regular texture and thin liquid Record review of Resident #1 ' s Progress Note written by LVN D dated [DATE] revealed Resident #1 choked on a piece of meat. Resident #1 was able to spit the meat out. Did not appear aspirate. Resident #1 ' s family member called local police because he felt Resident #1 was Not Doing Well. Resident #1 is vitally stable and blood sugar level is 129. Oxygen via nasal intact, oxygen 93% on 3LPM. EMS arrived and will be taking residents to local hospital Record review of Resident #1 ' s EMS record dated [DATE] revealed they arrived at resident at 2:13 pm, patient is unresponsive with rapid breathing presented to be laying supine on her bed in nursing home. Patient had trouble breathing and was breathing rapidly. Family called 911 and gave report to EMS. Patient was assessed and did have rapid breathing at about 35 breathes per minute and did have wheezing on the left side ofver lungs with diminshed lung sounds to the right. Patient was placed on a mass nonrebreather at 15 ml per minute. Patient had an initial saturation of 58%. Record review of Resident #1 ' s local hospital emergency department dated [DATE] revealed diagnoses of altered mental status, aspiration of food, and respiratory failure (difficulty to breathe) Record review of Resident # ' s1 local hospital consultation note dated [DATE] revealed reason for consultation patient sedated and intubated upon evaluation. History of present illness revealed patient was emergently intubated in the emergency department and bronchoscopy was performed by Doctor but unable to remove the entire choked material. Record review of Resident #1 ' s local hospital discharge summary dated [DATE] revealed palliative following morning, the patients RP came to bedside and change to code status to DNR. The patient died at 2:53 am on [DATE]. Record review of Resident #1 ' s Death Certificate dated [DATE], indicated cause of Death was Acute on chronic Respiratory failure with hypoxia, Aspiration Pneumonia, Aspiration of food, and Sequelae of choking. During an interview on [DATE] at 10:21 AM with CNA C revealed on [DATE] at 1:30 PM-2:00 PM, CNA C was told by Resident #1 ' s family member , who was present in Resident #1 ' s room, that Resident #1 had stopped eating and speaking when he was feeding her as they were conversing. CNA C gave Resident #1 water and patted Resident #1 on the back, just in case she had food in her throat. CNA C denied seeing Resident #1 turning blue, struggling for air, nor coughing. CNA C stated she went to get LVN D at that time. (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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:58 PM, with LVN D revealed she assessed Resident #1 on [DATE] around 1:30 PM-2:00 Pm and found no sign or symptoms of choking or aspiration. LVN D stated she took vital signs that were within normal range and had not seen any respiratory distress and Resident #1 was able to talk. LVN D stated she took Resident #1 vitals and oxygen level, she stated she did not have her stethoscope with her to listen to lung sounds because it was missing. LVN D stated Resident #1 did not appear in respiratory distress. LVN D stated Resident #1 did not have any swallowing issues and was redirected to eat slow. LVN D stated there were no restrictions to her diet she had a regular diet with thin consistency. LVN D stated Resident #1 son went to let her know he would be calling 911; she stated she went to assess her again and did not see any distress and told Resident #1 family to call 911 while she got Resident #1 paperwork ready. During an interview on [DATE] at 10:57 AM with CNA B revealed at around 2:00P on [DATE], CNA B initiated initial rounds starting her evening (,d+[DATE]pm). CNA B stated when entered Resident #1 ' s room CNA B observed Resident #1 was slouching down in her bed, was turning blue around her lips, Resident #1 appeared rigid and loose, and was struggling to breathe. CNA B repositioned Resident #1 to see if it would help improve her breathing. CNA B did not notify LVN D as she was told by the family member that LVN D had already completed an assessment of Resident #1 and found nothing to be wrong with Resident #1. CNA B stated she told Resident #1 family member if i were you I'd call 911. During an interview on [DATE] at 12:25 PM the Family member stated he was told by CNA B to go call 911 on [DATE] little after 2 PM. The Family member went to the nurse ' s station to notify LVN D to call 911 but LVN D stated if he wanted to call he could. The Family member called 911. During an interview on [DATE] at 1:31 pm, the DON stated she would have expected for LVN D to have checked Resident #1 airway and use stethoscope to listen to lung sounds. DON stated she was not aware that CNA B saw the resident in distress and did not report it to the nurse. During an interview on [DATE] at 3:31 pm, the Physician stated if Resident #1 was seen turning blue and with difficulty in breathing the staff should had taken immediate action to call 911 to get further evaluation at the emergency room . Record review of the Facility Foreign Body Airway Obstruction Management (Choking) dated ,d+[DATE], revealed, If a resident is coughing forcefully and is able to speak, monitor the situation and intervene if the condition doesn't improve, following the guidelines for performing Heimlich maneuver. If the resident becomes unconscious, lower resident to the ground, call for help and activate the emergency response system. Clear the airway only if the object is seen using the finger sweep motion. Initiate CPR if indicated. The policy did not specify what type of assessemnet to conduct. The Administrator and the DON were informed on [DATE] at 1:15 PM, that an Immediate Jeopardy (IJ) had been identified and a copy of the IJ Template identifying the areas of non-compliance, elements of risk, and need for immediate action were provided to the Administrator and a Plan of Removal was requested. The Plan of Removal was accepted on [DATE] and read: Alleged Issues: The facility failed to ensure resident #1 was free from neglect when they failed to implement their system for a choking resident, when they failed to activate the emergency response system. (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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: Facility will be in compliance with federal health, safety, and/or quality regulations. Its employees or service providers are to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Approaches: The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. Nursing staff will be in-serviced to respond to medical emergencies for residents, staff, and visitors. The employee who first witnesses or is first on site of a medical emergency, will initiate immediate action, (if trained), including CPR as appropriate, basic first aid, or (if not trained), summon for assistance immediately. Staff will not leave the resident unattended until appropriate nursing personnel are on site. A nurse will assess the situation and determine the severity of the emergency. If necessary, designate a staff member to perform emergency response including calling EMS if necessary. This in-service was initiated on [DATE]. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. The facility medical Director was informed of the IJ on [DATE] by the Facility Administrator. Resident #1 expired in the hospital [DATE]. All nursing staff will be in serviced, that if they are notified of a change in condition, they must immediately go assess the resident. This in-service was initiated on [DATE]. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. All nurses will be required to notify the DON of any changes in condition that require higher level of care, prior to transfer The DON will review new hire orientation packet to ensure these above in services are completed prior to the first shift on the floor. DON will provide in-service to nurses to Changes in condition will be reviewed using the SBAR/E-Interact Change of Condition form will be utilized in the EMR, and a change of condition note will be opened every shift for at least 72 hours to monitor. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. The DON has completed in-service education on [DATE], with the RN weekend supervisor regarding supervisor to round on all residents on the weekend, on all residents in facility to ensure no changes in condition are in progress, that have not been previously addressed. Monitoring: The 24-hour report in the EMR which runs all progress notes in real time, will be monitored daily in the clinical meeting for changes in condition by the clinical team, DON/ADON/MDS. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON or designee will perform random in person audits with nursing staff to ensure they understand the emergency response procedure, as well as notification of changes in condition, at least 3 nursing staff daily X1 month. This process began [DATE]. Changes in condition will be reviewed using the SBAR/E-Interact Change of Condition form will be utilized in the EMR, and a change of condition note will be opened every shift for at least 72 hours to monitor. The DON/Clinical team will monitor daily in clinical meeting to ensure changes in condition are addressed and interventions in place. This process began [DATE]. DON/ADON ' s will make rounds daily M-F, the weekend RN supervisor will round on all residents on the weekend, on all residents in facility to ensure no changes in condition are in progress, that have not been previously addressed, daily X 1 month. This process began [DATE]. Assessment: The Director of Nursing reviewed the 24-hour report on [DATE], to ensure there were no changes in condition that she was not aware of. On [DATE] the DON made rounds on all residents in the facility to ensure there were no residents who had a change in condition that was not already identified. On [DATE], the Regional Clinical Support Specialist added at risk residents with respiratory disorders or dysphagia to the CNA Kardex for increased monitoring during meals. QAPI Committee review: An interim QAPI committee meeting will be completed on [DATE]. IDT will review for compliance monthly in QAPI X3 months. The Plan of Removal revealed the facility took the following actions: Record review [DATE]: 1. QAPI dated [DATE]: this QAPI meeting is being conducted to discuss the plan of removal for IJ received on [DATE]. Attached is the plan of removal and the steps we will follow to ensure compliance has been met. attendance: Administrator, DON, medical director, IPC, regional clinical. 2. In-service dated [DATE]: making rounds on all residents on the Saturday and Sunday to assess for change of condition and report to DON. This is documented in midnight census. signed by RN S. 3. In-service dated [DATE]: DON will be notified of each change in condition that may require a higher level of care, immediately and transfer as needed. DON will ask staff if a head-to-toe assessment was completed and results. signed by DON. 4. In-service dated [DATE]: change in condition reporting (MD/nurse/RP) and response to medical emergencies. CNA to contact DON if nurse does not asses resident. signed by staff on several shifts. 5. In-service dated [DATE]: providing care to include assessing, evaluating, and responding to resident needs. signed by staff on several shifts. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Midnight census dated [DATE]: tool used by the DON and checked off on all stating she laid on eyes on all residents, stated 1 was in the hospital and 2 were ordered UA ' s. No respiratory/dysphagia concerns identified. Interviews on [DATE] started from 8:54 am- 10:58 am revealed: CNA G, LVN H, CNA I, CNA J, LVN D, CNA K, CNA N, LVN O, CNA P, CNA Q, LVN R, CNA T, CNA U, CNA V confirmed receiving in-services for reporting changes in condition to the charge nurse; when changes in condition are reported to the nurse, they will conduct a head to toe assessment and report changes and condition and head to toe assessment to ADON/DON, RP, and MD. CNA to contact DON if nurse does not assess resident. Providing care to include assessing, evaluating, and responding to residents needs. If a medical emergency the CNA is to stay by resident ' s bedside and yell out for help. RN S confirmed receiving in-service on making rounds on all residents on the Saturday and Sunday to assess for change of condition and report to DON and would documented in midnight census. DON stated staff were in-serviced on: RN would be making rounds on all residents on Saturdays and Sundays using the midnight census and any findings would be documented on the midnight census. She will be notified of each change in condition that may require a higher level of care, immediately and transfer as needed. The DON will ask staff if a head-to-toe assessment was completed and results. Change in condition reporting (MD/nurse/RP) and response to medical emergencies. CNA to contact DON if nurse does not assess resident. Providing care to include assessing, evaluating, and responding to resident needs. The DON stated she checked all residents off on the census stating she laid on eyes on all residents, stated 1 was in the hospital and 2 were ordered UA ' s. No respiratory/dysphagia concerns identified. The DON stated she was in-serviced on being notified of changes in condition and ask for head-to-toe assessment results. The Physician stated he was notified of the IJ. The Administrator stated the physician was notified of the IJ. The Administrator stated the DON did all the in-services and he held the QAPI meeting on [DATE]. Observations on [DATE] from 9:47 am- 10:48 am revealed: CNA P was able to identify Resident #6 with respiratory distress and showed Resident #6 ' s kardex that revealed if resident appears to have respiratory change, staff member to notify nurse for assessment. CNA Q was able to identify Resident #11 with respiratory distress and showed Resident #11 ' s kardex that revealed if resident appears to have respiratory change, staff member to notify nurse for assessment. CNA T was able to identify Resident #12 with dysphagia and showed Resident #12 ' s kardex that revealed monitor/ document/ report as needed any signs and symptoms of dysphagia. Pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing. Refusing to eat. Appears concerned during meals. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA U was able to identify Resident #13 ' s with dysphagia and showed Resident #13 ' s kardex that revealed monitor/ document/ report as needed any signs and symptoms of dysphagia. Pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing. Refusing to eat. Appears concerned during meals. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 11:15 AM. The facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #1) reviewed for change in condition. On [DATE] around 2PM, CNA B failed to report to LVN D that CNA B observed Resident #1 had blue lips and difficulty breathing. CNA B failed to report Resident #1's change in condition to LVN D so that LVN D could reassess Resident #1. LVN D, when notified by the family that they were requesting 911 called responded that they (the family) could call 911 if they wanted. LVN D failed to re-assess Resident #1 by not checking her lung sounds, attempting the Heimlich maneuver, and staying with the Resident #1 to determine if she was choking, aspirating, or developing difficulty with chewing or swallowing. The Family contacted 911 and EMS arrived and transferred Resident #1 to the hospital. Resident #1 was intubated at the local hospital, and expired on [DATE]. An IJ (immediate jeopardy) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:15 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a severity of more than minimal harm at a scope of isolated because all staff had not been trained on reporting changes in condition. This failure placed residents at risk for not being assessed by nursing staff, and serious changes of condition going unrecognized and untreated. Findings included: Record review of Resident #1 ' s face sheet dated [DATE], revealed, an [AGE] year-old female admitted on [DATE], diagnosed with Muscle weakness, Acute Respiratory failure with Hypoxia (not enough oxygen in the blood) she was a full code status. Record review of Resident #1 ' s quarterly MDS dated [DATE], revealed ADLs for feeding to be Independent to setup or clean up assistance. Resident #1 ' s BIMS score was a 15 score, indicating no cognitive impairment. There was no indication of swallowing issues. Record review of Resident #1 ' s physician order dated [DATE] revealed no concentrated sweets, diet regular texture, thin consistency. Record review of Resident #1 ' s Nutrition Risk assessment dated [DATE], revealed Regular Diet and Thin liquids. Record review of Resident #1 ' care plan dated [DATE] revealed focus area of receiving a therapeutic or altered consistency diet and it at risk for nutritional impairment with no concentrated sweets, regular texture and thin liquid (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1 ' s Progress Note written by LVN D dated [DATE] revealed Resident #1 choked on a piece of meat. Resident #1 was able to spit the meat out. Did not appear aspirate. Resident #1 ' s family member called local police because he felt Resident #1 was Not Doing Well. Resident #1 is vitally stable and blood sugar level is 129. Oxygen via nasal intact, oxygen 93% on 3LPM. EMS arrived and will be taking residents to local hospital. Record review of Resident #1 ' s EMS record dated [DATE] revealed they arrived at resident at 2:13 pm, patient is unresponsive with rapid breathing presented to be laying supine on her bed in nursing home. Patient had trouble breathing and was breathing rapidly. Family called 911 and gave report to EMS. Patient was assessed and did have rapid breathing at about 35 breathes per minute and did have wheezing on the left side of her lungs with diminished lung sounds to the right. Patient was placed on a mass nonrebreather at 15 ml per minute. Patient had an initial saturation of 58%. Record review of Resident #1 ' s local hospital emergency department dated [DATE] revealed diagnoses of altered mental status, aspiration of food, and respiratory failure (difficulty to breathe) Record review of Resident # ' s1 local hospital consultation note dated [DATE] revealed reason for consultation patient sedated and intubated upon evaluation. History of present illness revealed patient was emergently intubated in the emergency department and bronchoscopy was performed by Doctor but unable to remove the entire choked material. Record review of Resident #1 ' s local hospital discharge summary dated [DATE] revealed palliative following morning, the patients RP came to bedside and change to code status to DNR. The patient died at 2:53 am on [DATE]. Record review of Resident #1 ' s Death Certificate dated [DATE], indicated cause of Death was Acute on chronic Respiratory failure with hypoxia, Aspiration Pneumonia, Aspiration of food, and Sequelae of choking. During an interview on [DATE] at 10:21 AM with CNA C revealed on [DATE] at 1:30 PM-2:00 PM, CNA C was told by Resident #1 ' s family member, who was present in Resident #1's room, that Resident #1 had stopped eating and speaking when he was feeding her as they were conversing. CNA C gave Resident #1 water and patted Resident #1 on the back, just in case she had food in her throat. CNA C denied seeing Resident #1 turning blue, struggling for air, nor coughing. CNA C stated she went to get LVN D at that time. During an interview on [DATE] at 12:58 PM, with LVN D revealed she assessed Resident #1 on [DATE] around 1:30 PM-2:00 Pm and found no sign or symptoms of choking or aspiration. LVN D stated she took vital signs that were within normal range and had not seen any respiratory distress and Resident #1 was able to talk. LVN D stated she took Resident #1 vitals and oxygen level, she stated she did not have her stethoscope with her to listen to lung sounds because it was missing. LVN D stated Resident #1 did not appear to be in respiratory distress. LVN D stated Resident #1 did not have any swallowing issues and was redirected to eat slow. LVN D stated there were no restrictions to her diet she had a regular diet with thin consistency. LVN D stated Resident #1 son went to let her know he would be calling 911; she stated she went to assess her again and did not see any distress and told Resident #1 family to call 911 while she got Resident #1 paperwork ready. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:57 AM with CNA B revealed at around 2:00P on [DATE], CNA B initiated initial rounds starting her evening (,d+[DATE]pm). CNA B stated when entered Resident #1 ' s room CNA B observed Resident #1 was slouching down in her bed, was turning blue around her lips, Resident #1 appeared rigid and loose, and was struggling to breathe. CNA B repositioned Resident #1 to see if it would help improve her breathing. CNA B did not notify LVN D as she was told by the family member that LVN D had already completed an assessment of Resident #1 and found nothing to be wrong with Resident #1. CNA B stated she told Resident #1 family member if i were you I'd call 911. During an interview on [DATE] at 12:25 PM the Family member stated he was told by CNA B to go call 911 on [DATE] little after 2 PM. The Family member went to the nurse's station to notify LVN D to call 911 but LVN D stated if he wanted to call he could. The Family member called 911. During an interview on [DATE] at 1:31 pm, the DON stated she would have expected for LVN D to have checked Resident #1 airway and use stethoscope to listen to lung sounds. DON stated she was not aware that CNA B saw the resident in distress and did not report it to the nurse. During an interview on [DATE] at 3:31 pm, the Physician stated if Resident #1 was seen turning blue and with difficulty in breathing the staff should had taken immediate action to call 911 to get further evaluation at the emergency room . Record review of the Facility Foreign Body Airway Obstruction Management (Choking) dated ,d+[DATE], revealed, If a resident is coughing forcefully and is able to speak, monitor the situation and intervene if the condition doesnt improve, following the guidelines for performing Heimlich maneuver. If the resident becomes unconscious, lower resident to the ground, call for help and activate the emergency response system. Clear the airway only if the object is seen using the finger sweep motion. Initiate CPR if indicated. The policy did not specify what type of assessment to conduct. The Administrator and the DON were informed on [DATE] at 1:15 PM, that an Immediate Jeopardy (IJ) had been identified and a copy of the IJ Template identifying the areas of non-compliance, elements of risk, and need for immediate action were provided to the Administrator and a Plan of Removal was requested. The Plan of Removal was accepted on [DATE] and read: Alleged Issues: The facility failed to ensure resident #1 was free from neglect when they failed to implement their system for a choking resident, when they failed to activate the emergency response system. Goal: Facility will be in compliance with federal health, safety, and/or quality regulations. Its employees or service providers are to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Approaches: The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing staff will be in-serviced to respond to medical emergencies for residents, staff, and visitors. The employee who first witnesses or is first on site of a medical emergency, will initiate immediate action, (if trained), including CPR as appropriate, basic first aid, or (if not trained), summon for assistance immediately. Staff will not leave the resident unattended until appropriate nursing personnel are on site. A nurse will assess the situation and determine the severity of the emergency. If necessary, designate a staff member to perform emergency response including calling EMS if necessary. This in-service was initiated on [DATE]. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. The facility medical Director was informed of the IJ on [DATE] by the Facility Administrator. Resident #1 expired in the hospital [DATE]. All nursing staff will be in serviced, that if they are notified of a change in condition, they must immediately go assess the resident. This in-service was initiated on [DATE]. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. All nurses will be required to notify the DON of any changes in condition that require higher level of care, prior to transfer The DON will review new hire orientation packet to ensure these above in services are completed prior to the first shift on the floor. DON will provide in-service to nurses to Changes in condition will be reviewed using the SBAR/E-Interact Change of Condition form will be utilized in the EMR, and a change of condition note will be opened every shift for at least 72 hours to monitor. The Director of Nursing, Clinical Support Specialist, and ADON ' s will deliver all following in service education to nurses one on one. All nursing staff will be in serviced prior to them arriving to the facility for their next shift. The DON has completed in-service education on [DATE], with the RN weekend supervisor regarding supervisor to round on all residents on the weekend, on all residents in facility to ensure no changes in condition are in progress, that have not been previously addressed. Monitoring: The 24-hour report in the EMR which runs all progress notes in real time, will be monitored daily in the clinical meeting for changes in condition by the clinical team, DON/ADON/MDS. The DON or designee will perform random in person audits with nursing staff to ensure they understand the emergency response procedure, as well as notification of changes in condition, at least 3 nursing staff daily X1 month. This process began [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Changes in condition will be reviewed using the SBAR/E-Interact Change of Condition form will be utilized in the EMR, and a change of condition note will be opened every shift for at least 72 hours to monitor. The DON/Clinical team will monitor daily in clinical meeting to ensure changes in condition are addressed and interventions in place. This process began [DATE]. DON/ADON ' s will make rounds daily M-F, the weekend RN supervisor will round on all residents on the weekend, on all residents in facility to ensure no changes in condition are in progress, that have not been previously addressed, daily X 1 month. This process began [DATE]. Assessment: The Director of Nursing reviewed the 24-hour report on [DATE], to ensure there were no changes in condition that she was not aware of. On [DATE] the DON made rounds on all residents in the facility to ensure there were no residents who had a change in condition that was not already identified. On [DATE], the Regional Clinical Support Specialist added at risk residents with respiratory disorders or dysphagia to the CNA Kardex for increased monitoring during meals. QAPI Committee review: An interim QAPI committee meeting will be completed on [DATE]. IDT will review for compliance monthly in QAPI X3 months. The Plan of Removal revealed the facility took the following actions: Record review [DATE]: 1. QAPI dated [DATE]: this QAPI meeting is being conducted to discuss the plan of removal for IJ received on [DATE]. Attached is the plan of removal and the steps we will follow to ensure compliance has been met. attendance: Administrator, DON, medical director, IPC, regional clinical. 2. In-service dated [DATE]: making rounds on all residents on the Saturday and Sunday to assess for change of condition and report to DON. This is documented in midnight census. signed by RN S. 3. In-service dated [DATE]: DON will be notified of each change in condition that may require a higher level of care, immediately and transfer as needed. DON will ask staff if a head-to-toe assessment was completed and results. signed by DON. 4. In-service dated [DATE]: change in condition reporting (MD/nurse/RP) and response to medical emergencies. CNA to contact DON if nurse does not assess resident. signed by staff on several shifts. 5. In-service dated [DATE]: providing care to include assessing, evaluating, and responding to resident needs. signed by staff on several shifts. 6. Midnight census dated [DATE]: tool used by the DON and checked off on all stating she laid on eyes on all residents, stated 1 was in the hospital and 2 were ordered UA ' s. No respiratory/dysphagia concerns identified. Interviews on [DATE] started from 8:54 am- 10:58 am revealed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 11:15 AM. The facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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** 46998 Based on observations, interviews, and record reviews the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 5 (Resident #3, Resident #4, Resident #5, Resident #9, and Resident #10) of 10 residents observed for oxygen management and 6 (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) of 15 rooms observed for oxygen sign postings, and 1 (Resident#5) of 5 residents reviewed for oxygen orders. Resident #3's oxygen tank was empty behind his wheelchair. Resident #4's oxygen tank behind her wheelchair in her room was empty. Resident #5's oxygen tank was on empty behind his wheelchair while he was in the dining area. Resident #9's oxygen tank was empty behind her wheelchair she was in the dining area. Resident #10's oxygen tank was empty behind her wheelchair in her room. Residents on oxygen in Rooms 207, 211, 215, 302, 303, 315, 316, did not have oxygen signs posted outside their bedrooms. Resident #5 had no orders for oxygen but was using oxygen. These failures could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. Findings include: Resident #3 Record review of Resident #3's face sheet dated 11/05/24, revealed, admission on 08/01/23 and re-admission on 10/03/24 to the facility. Record review of Resident #3's facility history and physical dated 05/22/24, revealed, an [AGE] year-old male diagnosed with Alzheimer Dementia, hypoxia (a dangerous condition that occurs when your body does not have enough oxygen in the blood, tissues, or cells to function normally) likely due to pulmonary edema (Too much fluid in the lungs)/pleural effusion (buildup of excess fluid between the layers of the pleura outside of your lungs) ESBL. Record review of Resident #3's 5-day MDS dated [DATE], revealed, no BIMS was taken to measure the cognitive status of the resident Resident #3 was diagnosed with Non-Alzheimer's Dementia and Respiratory Failure, Acute respiratory failure with hypoxia, and muscle weakness. Resident #3 was coded for oxygen therapy - continuous. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's orders dated 10/03/24, revealed, Oxygen at 2 liter per minute via nasal cannula. Record review of Resident #3's care plan dated 08/09/24, revealed, requires oxygen therapy related to respiratory failure with hypoxia. Monitor for s/s of respiratory distress and report to MD as needed. Respirations, pulse, oximetry. Oxygen setting at 2 liter per minute via nasal cannula continuously. Observation on 10/24/24 at 10:16 AM, revealed, Resident #3 was lying down in bed asleep on his concentrator. Next to the bed was a wheelchair with an oxygen tank in the back. The nasal cannula was seen hanging all the way down to the left side wheel and not bagged. The gage on the oxygen tank was reading empty on the white area. Resident #4 Record review of Resident #4's face sheet dated 11/05/24, revealed, admission on 02/29/24 and re-admission on 04/29/24 to the facility. Record review of Resident #4's facility history and physical dated 03/06/24, revealed, a [AGE] year-old female diagnosed with dysarthria (difficulty speaking clearly due to muscles used to speak are weak or not working properly.) and weakness. Record review of Resident #4's annual MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 5 to be able to make daily decisions and recall information. Resident #4 was coded for oxygen therapy. Record review of Resident #4's orders dated 05/06/24, revealed, oxygen at 4 liter per minute via nasal cannula continuous. May remove for ADLs. Record review of Resident #4's care plan reviewed on 11/05/24 revealed there was no care plan for oxygen therapy. Observation and interview on 10/24/24 at 1:32 PM, with Resident #4. Resident #4 was in bed with nasal cannula on. Resident #4 stated she does use her wheelchair and had used it prior to being in bed that day. Resident #4 stated nursing staff do change out her oxygen tank. Resident #4's oxygen tank was placed behind her wheelchair. The oxygen tank read empty. Resident #4 stated she had just sat in her wheelchair earlier but could not remember if there was oxygen coming out or not. Resident #5 Record review of Resident #5's face sheet dated 11/05/24, revealed, admission on 09/11/24 to the facility. Resident #5's profile picture had Resident #5 wearing his nasal cannula. Record review of Resident #5's facility history and physical dated 09/17/24, revealed, an [AGE] year-old female diagnosed with COPD and history of tobacco smoking. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's admission MDS dated [DATE], revealed, a moderately cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #5 was diagnosed with respiratory failure and one of the following asthma, COPD, or Chronic Lung disease. Resident was not coded for oxygen therapy. Record review of Resident #5's orders reviewed on 10/22/24, revealed, no orders for oxygen therapy. Record review of Resident #5's baseline care plan dated 09/17/24, revealed, coded for oxygen therapy. Observation on 10/23/24 at 3:04 PM, revealed, Resident #5 in bed with his nasal cannula on and concentrator on. Oxygen tank was seen behind Resident #5's wheelchair. Observation and interview on 10/28/24 at 3:59 PM, with Resident #5, revealed, Resident #5 to have his nasal cannula on while in the dining room. Resident #5's oxygen tank was placed behind his wheelchair reading empty with arrow on white mark on tank. Resident #5 was not coughing nor struggling to breathe. Resident #5 stated he did not know his oxygen tank was out. Resident #5 stated it needed to be changed. Resident #5 stated he was okay. Observation and interview on 10/28/24 at 4:04 PM, with LVN Z. LVN Z used the oximeter which read 88 percent oxygen saturation. A second try was taken revealing it to be in the 90s. LVN Z stated sometimes when residents move the reading could be off. LVN Z stated it was everyone's responsibility for ensuring the oxygen tanks were full. LVN Z stated the risk again was de-saturation of oxygen. Resident #9 Record review of Resident #9's face sheet dated 11/05/24, revealed, admission on 02/23/23 and re-admission on 08/05/24 to the facility. Record review of Resident #9's facility history and physical dated 09/19/24, revealed a [AGE] year-old male diagnosed with COPD and chronic hypoxia respiratory failure. Record review of Resident #9's 5-day MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 3 to be able to recall information or make daily decisions. Resident #9 was diagnosed with asthma and respiratory failure, chronic respiratory failure with hypoxia. Resident was not coded for oxygen therapy. Record review of Resident #9's care plan dated 08/22/24, revealed, at risk of respiratory infections/distress, hypoxia, shortness of breath, and cough related to COPD. Administrator medications as ordered. Administrator oxygen as ordered. Record review of Resident #9's orders dated 08/08/24, revealed oxygen at 2 liters per minute via nasal cannula to maintain saturation level greater than 90 percent related to asthma and COPD (a common lung disease that makes it difficult to breathe). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/28/24 at 3:59 PM, with Resident #9. Resident #9 had her nasal cannula on in the dining room. Oxygen tank behind her wheelchair read empty with arrow pointing on white. Resident #9 was not struggling to breathe nor coughing or wheezing for air. Resident #9 shook her heading indicating she was fine when asked if she was okay and able to breathe. Observation and interview on 10/28/24 at 4:02 PM, with LVN Z. LVN Z used the oximeter which read 87 percent oxygen saturation. A second try was taken revealing it to be in the 90s. LVN Z stated everyone was responsible for ensuring the oxygen tanks were full and if one was on empty then they would have to change it. LVN Z stated the risk could be de-saturation of oxygen. Resident #10 Record review of Resident #10's face sheet dated 11/05/24, revealed, admission on 02/01/21 and re-admission on 07/18/24 to the facility. Record review of Resident #10's facility history and physical dated 02/05/21 provided by the ADON, revealed, an [AGE] year-old female (actual age in 2024 - [AGE] year-old) diagnosed with Alzheimer and Diabetes Mellitus (chronic disease that occurs when the body cannot regulate blood sugar levels). Record review of Resident #10's quarterly MDS dated [DATE], revealed, a severely impaired cognitive BIMS score of 5 to be able to recall or make daily decisions. Resident #10 was diagnosed with Non-Alzheimer's Dementia, Alzheimer's Disease, and muscle wasting. Resident #10 was not coded for oxygen therapy. Record review of Resident #10's orders dated 08/23/22, revealed, oxygen at 2-3 liter per minute via nasal cannula as needed for any s/s of Shortness of Breath and dyspnea (the frightening sensation of being unable to breathe normally or feeling suffocated). Record review of Resident #10's care plan dated 11/05/24, revealed, impaired gas exchange related to lung consolidation (bringing together some large number of items into a single, smaller number) related to pneumonia (infection of one or both of the lungs to fill with fluid or pus, making it difficult to breath). Administer oxygen as ordered: none ordered at this time. Monitor oxygen saturation through pulse oximetry every shift as needed, maintaining oxygen saturation of 90 percent or greater. During an interview on 10/23/24 at 4:11 PM, with CNA W, she stated, the CNAs were responsible for ensuring the oxygen tanks that were being used by residents on oxygen was full. CNA W stated when changing out a tank we must inform the nurse and the driver of the amount of oxygen in the tank. CNA W stated there could be a risk of low oxygen. During an interview on 10/23/24 at 4:21 PM, with the Transporter, she stated, anytime residents who have oxygen and being transported anywhere, are to be checked by the transporter to ensure the residents have oxygen in their tank(s). The Transporter stated not ensuring the oxygen tanks were full could result in the resident stopping from breathing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/24/24 at 4:30 PM, with Resident #10, revealed, she was in room wearing a nasal cannula with her oxygen tank behind her wheelchair on empty with the arrow reading white. Resident #10 stated she was fine. Resident #10 did was not wheezing, coughing, or struggling for air. Observation and interview on 10/24/24 at 4:37 PM, with LVN U and Resident #10. LVN U stated the oxygen tank was empty and there was no air coming out of the nasal cannula. LVN U was observed grabbing the nasal cannula and checking it for air. LVN U stated the CNA on duty should have changed the tank. LVN U used the oximetry (an electronic device that measures the saturation of oxygen carried in your red blood cells) and revealed Resident #10 to be in the 90s. LVN U stated the risk could be de-saturation of oxygen. During an interview on 10/23/24 at 11:56 AM, with Physician X, she stated the nurses and drivers were responsible for ensuring the oxygen tanks for resident on oxygen were full. The Physician X stated the risk could be de-saturation of the resident. During an interview on 10/25/24 at 11:09 AM, with the DON, she stated, everyone was responsible for ensuring the oxygen tanks were full and not in the red. The DON stated the risk could be desaturation. No Oxygen Sign During an interview on 10/23/24 at 11:56 AM, with Physician X, she stated that an oxygen sign needed to be posted outside of a resident's room who was on oxygen to prevent someone from smoking. Observation on 10/23/24 at 2:50 PM, revealed, in room [ROOM NUMBER] to have no oxygen sign posted. Oxygen tank was placed behind a wheelchair in the room. Observation on 10/23/24 at 3:04 PM, revealed, in room [ROOM NUMBER] was on oxygen as concentrator could be seen and heard. Outside of the room there was no oxygen sign posted. Observation on 10/23/24 at 3:18 PM, revealed, in room [ROOM NUMBER] the concentrators could be heard and were seen. In the restroom there was a wheelchair in the shower room with an oxygen tank. Outside of room [ROOM NUMBER] there was no oxygen sign posted. During an interview on 10/24/24 at 10:09 AM, with LVN Y, he stated, the CNAs and nurses were expected to be checking the oxygen tanks on residents who were on oxygen. LVN Y stated the risk would be low oxygen saturation. LVN Y stated anyone on oxygen needed to have oxygen signs posted outside of their rooms. LVN Y stated this was so everyone was aware oxygen was being used in the room and could result in combustion and fire. Observation on 10/24/24 at 1:25 PM, revealed, in room [ROOM NUMBER] a black concentrator heard to be on. There was no oxygen sign posted outside of room [ROOM NUMBER]. Observation on 10/24/24 at 1:32 PM, revealed, in room [ROOM NUMBER] that there was a black and blue concentrator in the room. A black concentrator was heard to be on. Outside of room [ROOM NUMBER], there was no oxygen sign posted. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/24/24 at 1:32 PM, revealed, in room [ROOM NUMBER] there was no oxygen sign posted. Oxygen tank was observed placed behind a wheelchair and concentration was heard to be on. Observation on 10/25/24 at 9:44 AM, revealed, in room [ROOM NUMBER], there to be two concentrators on. Outside of room [ROOM NUMBER] there was no oxygen sign posted. During an interview on 10/25/24 at 11:09 AM, with the DON, she stated, anybody on oxygen should have an oxygen sign posted outside of their rooms. The DON stated the risk could be an open flame. Record review of the facility Oxygen Administration policy dated 07/22, revealed, Policy: Oxygen was administrated to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen was administrated under orders of a physician. Oxygen warning signs must be placed on the door of the resident's room where oxygen was in use. Record review of the facility Oxygen Safety policy dated 07/22, revealed, Policy: It was the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. Oxygen Storage - Precautionary signs readable form 5 feet shall be maintained on the door or gate where oxygen was used or stored. Oxygen in Use - No smoking signs will be utilized to clearly identify oxygen was in use before connecting the oxygen supply and will remain in place until oxygen administration has been discontinued.

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	11/08/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 (Resident #3, Resident #4, Resident #5) of 10 residents and 1 (room [ROOM NUMBER]) of 6 rooms reviewed for infection control. 1. Resident #3's nasal cannula was not stored in a zip lock bag and or baggy. 2. Resident #4's nasal cannula was not stored in a zip lock bag and or baggy. 3. Resident #5's nasal cannula was not stored in a zip lock bag and or baggy. room [ROOM NUMBER] in the restroom was a nasal cannula that was hanging in the shower area and not in zip lock bag and or baggy. These failures could place residents at risk for infection due to improper care practices. Resident #3 Record review of Resident #3's face sheet dated 11/05/24, revealed, admission on 08/01/23 and re-admission on 10/03/24 to the facility. Record review of Resident #3's facility history and physical dated 05/22/24, revealed, an [AGE] year-old male diagnosed with Alzheimer Dementia, hypoxia (a dangerous condition that occurs when your body does not have enough oxygen in the blood, tissues, or cells to function normally) likely due to pulmonary edema (Too much fluid in the lungs)/pleural effusion (buildup of excess fluid between the layers of the pleura outside of your lungs) ESBL. Record review of Resident #3's 5-day MDS dated [DATE], revealed, no BIMS was taken to measure the cognitive status of the resident. Resident #3 was diagnosed with Non-Alzheimer's Dementia and Respiratory Failure, Acute respiratory failure with hypoxia, and muscle weakness. Resident #3 was coded for oxygen therapy - continuous. Record review of Resident #3's orders dated 10/03/24, revealed, Oxygen at 2 liter per minute via nasal cannula. Record review of Resident #3's care plan dated 08/09/24, revealed, requires oxygen therapy related to respiratory failure with hypoxia. Monitor for s/s of respiratory distress and report to MD as needed. Respirations, pulse, oximetry. Oxygen setting at 2 liter per minute via nasal cannula continuously. Observation on 10/24/24 at 10:16 AM, revealed, Resident #3 was lying down in bed asleep. Next to the bed was a wheelchair with an oxygen tank in the back. The nasal cannula was seen hanging all the way down to the left side wheel and not bagged. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 Record review of Resident #4's face sheet dated 11/05/24, revealed, admission on 02/29/24 and re-admission on 04/29/24 to the facility. Record review of Resident #4's facility history and physical dated 03/06/24, revealed, a [AGE] year-old female diagnosed with dysarthria (difficulty speaking clearly due to muscles used to speak are weak or not working properly.) and weakness. Record review of Resident #4's annual MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 5 to be able to make daily decisions and recall information. Resident #4 was coded for oxygen therapy. Record review of Resident #4's orders dated 05/06/24, revealed, oxygen at 4 liter per minute via nasal cannula continuous. May remove for ADLs. Record review of Resident #4's care plan reviewed on 11/05/24 reviewed there was no care plan for oxygen therapy. Observation on 10/24/24 at 1:32 PM, revealed, an oxygen tank placed behind Resident #4's wheelchair. The nasal cannula was placed over the shoulder of the wheelchair and not zip locked or bagged. Footrests were placed on top of the nasal cannula tubing. Resident #5 Record review of Resident #5's face sheet dated 11/05/24, revealed, admission on 09/11/24 to the facility. Resident #5's profile picture had Resident #5 wearing his nasal cannula. Record review of Resident #5's facility history and physical dated 09/17/24, revealed, an [AGE] year-old female diagnosed with COPD and history of tobacco smoking. Record review of Resident #5's admission MDS dated [DATE], revealed, a moderately cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #5 was diagnosed with respiratory failure and one of the following asthma, COPD, or Chronic Lung disease. Was not coded for oxygen therapy. Record review of Resident #5's orders reviewed on 10/22/24, revealed, no orders for oxygen therapy. Record review of Resident #5's baseline care plan dated 09/17/24, revealed, coded for oxygen therapy. Observation on 10/23/24 at 3:04 PM, revealed, Resident #5 in bed sleeping on his right side with his nasal cannula on and concentrator on. Oxygen tank was seen behind Resident #5's wheelchair. Nasal cannula on wheelchair was not stored bagged in a zip lock or baggy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 11:56 AM, with Physician X, she stated nasal cannulas were to be bagged to prevent contamination but has rarely seen them being bagged in the facility. Physician X stated they were hung on the wheelchair or somewhere and not on the floor. Physician X stated it was the nurse's responsibility to ensure they were bagged. Observation on 10/23/24 at 3:18 PM, revealed, in room [ROOM NUMBER] in the restroom there was a wheelchair in the shower room with an oxygen tank. The nasal cannula was not stored in a zip lock bag nor baggy and was daggling off the left back side in the air. During an interview on 10/23/24 at 4:11 PM, with CNA W, she stated, the nasal cannulas were to be stored in a zip lock bag or baggy to prevent them from becoming contaminated. During an interview on 10/24/24 at 10:09 AM, with LVN Y, he stated, the nasal cannulas were to be bagged to prevent bacteria from getting into the tubing. During an interview on 11/06/24 at 2:38 PM, with the DON. The DON stated nasal cannulas were to be stored in a bag for infection control. The DON stated the nursing staff were responsible for placing in the bags. Record review of the facility Infection Prevention Control Program policy dated 07/22, revealed, Policy: this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.