

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2024
NAME OF PROVIDER OR SUPPLIER  Patriot Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11490 Gateway North Blvd. El Paso, TX 79934	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</b></p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #9) of 7 residents reviewed for care plans</p> <p>-The facility failed to follow the comprehensive person-centered care plan for Resident #9's fall risk, by failing to have a fall mat in place next to bed while resident was lying down in bed.</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services as indicated in their comprehensive person-centered plans developed to address their needs.</p> <p>Findings include:</p> <p>Review of Resident #9's Admission Record dated 08/05/2024, revealed an [AGE] year-old female with an admitted [DATE]. Resident #9's diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness and abnormalities of gait and mobility.</p> <p>Review of Resident #9's quarterly MDS assessment dated [DATE], revealed a BIMS score of 02 indicating severe cognitive impairment. Section GG on Functional Abilities and Goals revealed resident requires substantial/maximal assistance with transfers. Section J - Health Conditions revealed resident had not had any falls since admission.</p> <p>Review of Resident #9's Order Summary Report dated 08/05/2024, revealed an order for a Fall mat in place at bedside every shift with an active date of 02/14/2023 and no end date.</p> <p>Review of Resident #9's comprehensive care plan dated 08/05/2024, revealed the resident was at risk for falls related to poor mobility. Part of the interventions included Fall Mat while in Bed for Safety.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 08/05/2024 at 9:13 a.m., Resident #9 lying in bed and visited resident in bedroom. Resident observed lying down in bed. Fall mat folded and positioned behind the headboard. Resident was rocking in bed. Resident #9 did not provide any responses when greeted or asked her name. Resident had her eyes closed.</p> <p>During an observation and interview on 08/05/2024 at 9:25 a.m., LVN I entered Resident #9's bedroom and observed the floor mat was folded and tucked behind Resident #9's headboard. LVN I said Resident #9 had breakfast and returned to her room where the CNAs assisted her to lay in bed. LVN I said Resident #9 was a fall risk and has a fall mat that is placed next to the bed while resident was on the bed. LVN I said the CNAs must have forgotten to put down the mat. LVN I said Resident #9 had not had any recent falls.</p> <p>During an interview on 08/05/2024 at 9:32 a.m., CNA J said she assisted Resident #9 back to bed after breakfast a short time after 8:30 a.m. CNA J said Resident #9 was a fall risk and needs a floor mat next to bed for fall protection. CNA J said Resident #9 had not fallen in a long time. CNA J said the fall mat must be used anytime the resident was in bed. CNA J said she must have forgotten to put the mat in place.</p> <p>During an interview on 08/05/2024 at 10:16 a.m., the DON said that Resident #9 requires the use of a fall mat anytime she was in bed due to fall risk. The DON said Resident #9 had not had any falls from bed and her last actual fall was 05/17/2024. The DON said the fall mat was a part of the interventions listed on the comprehensive care plan. The DON said the risk of failing to follow the care plan regarding fall protections was the resident could get hurt and have a possible serious injury.</p> <p>Review of facility-provided Comprehensive Care Plans policy dated February 2023, reads in part 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 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. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</b></p> <p>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 #10) of 3 residents observed for oxygen management.</p> <p>-Resident #10 was on oxygen and did not have oxygen signs posted outside his bedroom.</p> <p>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.</p> <p>Findings included:</p> <p>Review of Resident #10's Admission Record dated 07/31/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10's diagnoses included pulmonary embolism (condition in which one or more arteries in the lungs become blocked by a blood clot).</p> <p>Review of Resident #10's initial MDS assessment dated [DATE], revealed a BIMS score of 14 indicating the person is intact cognitively. Section O - Special Treatments, Procedures, and Programs revealed resident was on oxygen therapy.</p> <p>Review of Resident #10's Order Summary Report dated 08/05/2024, reflected in part an order for oxygen continuously via nasal cannula (NC), may titrate between 2-5 LPM via NC to maintain O2 sats above 90%.</p> <p>Review of Resident #10's care plan dated 08/05/2024, reflected in part, Resident #10 at risk for respiratory infections/distress, hypoxia (low levels of oxygen in body tissues), SOB, and cough. Resident is on 2LPM of continuous oxygen via nasal cannula.</p> <p>During an observation on 07/31/2024 at 3:35 p.m., revealed Resident #10 lying in bed using oxygen via nasal cannula. Observation outside of the bedroom entrance door revealed there was not a sign indicating oxygen in use/no smoking.</p> <p>During an interview on 07/31/2024 at 3:37 p.m., RN D said she believes there should have been an oxygen in use sign posted outside of Resident #10's bedroom entrance. RN D said the purpose of the sign was to let everyone know that the resident was on oxygen for safety purposes. RN D said nurses are responsible for posting the signs. RN D said she did not know why the sign was not posted.</p> <p>During an interview on 08/05/2024 at 10:16 a.m., the DON said the purpose of an oxygen in-use sign was to let visitors and others know that oxygen was being used in the room. The DON said the nurses in the hall are responsible for posting the signs. The DON said the risk was the patient could get harmed from someone not being aware that the patient is using oxygen, and the patient might not be monitored properly for oxygen use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility provided Oxygen Administration policy dated 2024, reflected in part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and Compliance Guidelines: 6. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use. 11. Staff shall monitor for complications associated with the use of oxygen and take precautions to prevent them. Possible risks and complications include but are not limited to: a. Fire; b. Respiratory infections related to contaminated humidification systems; c. Oxygen toxicity (signs include vertigo, nausea, convulsions); d. Ventilatory depression (slowed respiratory rate) associated with elevated carbon dioxide levels; e. Medical device-related pressure injuries.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45217</p> <p>Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 2 (Resident #1, and #2) of 8 residents reviewed for medical records.</p> <p>-The facility failed to ensure the right diet texture was documented in the orders of Resident #1.</p> <p>-The facility failed to ensure the right diet texture was documented in the care plan of Resident #1.</p> <p>-The facility failed to ensure accurate documentation was reflected in the Medication Administration Record of Resident #2.</p> <p>These failures could lead to errors in treatment and services provided based on incorrect information.</p> <p>Findings included:</p> <p>Resident #1:</p> <p>Review of Resident #1's Admission Record printed on 08/02/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 was discharged from the facility on 06/30/2024. Resident #1's diagnoses included gastro-esophageal reflux disease (condition in which acidic gastric fluid flows backward into the esophagus, resulting in heartburn), irritable bowel syndrome (intestinal disorder causing pain in the belly, gas, and constipation), and unspecified protein-calorie malnutrition (lack of sufficient energy or protein to meet the body's metabolic demands).</p> <p>Review of Resident #1's initial MDS assessment dated [DATE], revealed a BIMS score of 11 indicating moderate cognitive impairment. Section K - Swallowing/Nutritional Status reflected that resident with following possible swallowing disorder: loss of liquids from mouth when eating or drinking; and holding food in mouth/cheeks or residual food in mouth after meals. No weight loss of 5% in the last month. Resident on mechanically altered diet.</p> <p>Review of Resident #1's Orders printed on 08/02/2024, reads an order started on 06/27/2024 for regular diet, pureed texture, and clear liquids consistency diet.</p> <p>Review of Resident #1's care plan printed on 08/02/2024, reads in part, resident was receiving a therapeutic or altered consistency diet and was at risk for nutritional impairment. Regular diet, pureed texture, clear liquids consistency.</p> <p>Review of Resident #1's Admission Report Sheet dated 06/26/2024, reads in part that resident's diet was Regular with thin liquids.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's hospital discharge documentation revealed resident was on regular diet with no modified textures.</p> <p>During an interview on 07/31/2024 at 11:06 a.m., Resident #1's RP/FM said Resident #1 was at the facility for about four days. RP/FM said Resident #1 was eating a regular diet without a modified texture at the hospital and when he went to the facility, he started receiving pureed textured food at the facility and did not know why. RP/FM said the facility did not tell her why Resident #1 was given pureed food texture.</p> <p>During an interview on 07/31/2024 at 1:43 p.m., the DON said regarding Resident #1's diet, the facility follows the orders provided by the hospital. The DON said the facility received a report from the hospital on the diet and document on the Admission Report Sheet. The DON reviewed the Admission Report Sheet and discharge documentation and said Resident #1 came from the hospital with regular texture diet. The DON said she believes that she made a mistake and put the order in for pureed. The DON said she was the responsible person who had to complete orders for Resident #1. The DON said she put in the incorrect order. The DON said if it was brought to her attention, she would have addressed it. The DON said the issue was not brought to her attention at any time when the resident was here. The DON said that the order stayed that way until he was discharged on [DATE]. The DON said she did not receive any reports of the patient not eating his food. There were no weights documented for the resident's stay from 06/26/2024 to 06/30/2024. The DON said the risk of not accurately documenting the correct orders was the patient may not receive the proper treatment.</p> <p>During an interview on 08/01/2024 at 11:21 a.m., LVN E said he worked with Resident #1. LVN E said Resident #1 ate well and did not complain about the food.</p> <p>During an interview on 08/01/2024 at 11:28 a.m., CNA F said she worked with Resident #1. CNA F said he was independent and had no issue with eating. CNA F said resident ate well and he had no complaints about the food at the facility.</p> <p>Resident #2:</p> <p>Review of Resident #2's Admission Record printed on 08/01/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 was discharged from the facility on 06/29/2024. Resident #2's diagnoses included Chronic Obstructive Pulmonary Disease (lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of Resident #2's initial MDS assessment dated [DATE], revealed a BIMS score of 05 indicating severe cognitive impairment. Section J - Health Conditions reflected under Other Health Conditions that resident had shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring), and shortness of breath or trouble breathing when lying flat.</p> <p>Review of Resident #2's Order Summary Report printed on 08/01/2024, reflected an order for Formoterol Fumarate Inhalation Nebulization Solution 10 MCG/21ML , 1 applicator inhale orally via nebulizer two times a day for COPD.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's Care Plan printed on 08/01/2024, revealed Resident #2 was at risk for Respiratory infections/distress, hypoxia (low levels of oxygen in body tissues), SOB and cough related to diagnosis of COPD. Part of the interventions included administer medications/nebulizer treatment as ordered.</p> <p>Review of Resident #2's Medication Administration Record for June 2024, revealed missing initials on 06/20/2024, 06/23/2024, and 06/24/2024 for 9:00 a.m. administration of Formoterol Fumarate Inhalation Nebulization Solution.</p> <p>Review of Resident #2's Medication Administration Record for June 2024, revealed Resident #2's oxygen was checked every shift noting the following: on 06/20/2024: AM - 95, PM - 93, night - 94; 06/23/2024: AM - 97, PM - 95, night - 95; 06/24/2024: AM - 96, PM - 96, night - 96.</p> <p>During an interview on 08/05/2024 at 9:05 a.m., LVN H said she was responsible for the nebulizer treatment for Resident #2 on the dates with missing initials. LVN H said she knows that treatment was done. LVN H said Resident #2 did not have refusal behaviors. LVN H said medication was on hand. LVN H said the issue was most likely a computer glitch not showing administration was done.</p> <p>During an interview on 08/05/2024 at 10:16 a.m., the DON said she reviewed documentation regarding Resident #2 and did not find any medication errors or treatments. The DON said the nurse administering the medication was responsible to ensure they documented accurately. The DON said the risk of failing to document accurately could be being unable to verify if the patient got proper care and if they received proper treatment.</p> <p>Review of facility provided Documentation in Medical Record policy dated 2024, reads in part Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.</p>		