STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676468	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Rehabilitation and Wellness Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interviews and record reviews, the facility failed to thoroughly investigate allegations of abuse, neglect, exploitation, or mistreatment for 1 of 10 (Resident #1) reviewed for abuse. The facility failed to implement their abuse policy when they failed to immediately suspend CNA A after an allegation of mistreatment was reported. This failure could place residents at risk of potential continued mistreatment and abuse. Findings included: Record review of Abuse, Neglect and Exploitation policy dated 2024 read in part VI protection of resident: the facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: D- room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. Record review of Resident #1's face sheet dated 10/31/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of muscle weakness, other abnormalities of gait and mobility, and unspecified lack of coordination. Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated her cognitive was intact and she required moderate assistance with transfers. Record review of Resident #1's baseline care plan dated 10/18/24 revealed focus area for has an ADL self-care performance deficit with interventions that included requires assistance by staff to maximize independence with transferring. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #1's late entry progress note dated 10/27/24 written by RN C revealed this nurse was approached by [Resident #1 RP], who stated that she want to take [Resident #1] home right now, this nurse did ask [Resident #1 RP] what had happened, she stated that [Resident #1] was treated bad, when we went to the room the [Resident #1 RP] stated had [Resident #1] state what has happened. [Resident #1] stated that on her second day here that [Resident #1] legs were thrown into the bed, she stated that she had never reported it. [Resident #1 RP] than stated that [Resident #1] got pushed on her wheelchair, and that [Resident #1] hit her knee, I did look at [Resident #1] knee and there was no skin issues noted no redness noted. this nurse ask if she wanted [Resident #1] moved and also stated that there would be an investigation. [Resident #1 RP] stated that no she was going to take [Resident #1] home. I did go over [Resident #1] medication and told her which ones would need a scrip and which ones she could buy over the counter. I follow up with CNAs in the hall and asked them to write a statement on what had happened. [Resident #1 RP] did signed AMA and left with her [Resident #1] in their car.

During an interview on 10/27/24 at 2:08 pm, RN C stated she had worked the weekend of the alleged incident and was the supervisor. RN C stated she was called in to Resident #1's room by Resident #1's family and was told they wanted to take Resident #1 AMA. RN C stated Resident #1 had stated that she had been pushed against the wall in the wheelchair and her knee was hurting. RN C stated she assessed Resident #1 and did not see any swelling, bruising, scratches, or redness. RN C stated she followed up with CNA A who was assigned to Resident #1 and the aide had denied the allegations of pushing Resident #1 in wheelchair and bumping knee on the wall. RN C stated she spoke to CNA B who had been in the room when the alleged incident happened, and she denied seeing CNA A push Resident #1 against the wall in the wheelchair and hitting her knee. RN C stated she asked CNA A and CNA B to write statements and reported the allegation to the DON.

During an interview on 10/27/24 at 2:15 pm, CNA A stated was not aware of any injury when moving Resident #1. CNA A stated Resident #1's family just came to her, and stated Resident #1 had hurt her knee and was in pain. CNA A stated when the resident was moved to allow Resident #11 to pass, (they were roommates) Resident #1 did not verbalize any pain or that she was hurt against the wall. CNA A stated that Resident #1 would transfer herself alone and was very limited in help, she was very independent. CNA A stated she was asked to leave a statement with the DON in her box yesterday (10/26/24). CNA A stated the DON had not addressed an investigation since she (DON) returned to work on Monday (10/28/24). CNA A stated CNA B was in the room present when she moved Resident #1.

During an interview on 10/27/24 at 2:23 pm, CNA B stated she was in the room present with CNA A as they were helping Resident #1's roommate Resident #11 to the restroom. CNA B stated CNA A moved Resident #1 slightly towards the wall to allow Resident #11's wheelchair to pass as Resident #1 was sitting in her wheelchair near the walkway area to the restroom. CNA B stated at the time of moving Resident #1, nothing was verbalized by Resident #1 that she was in pain or had gotten hit. CNA B stated after 20 minutes Resident #1 had voiced pain to her knee to her and she reported it to the charge nurse. CNA B stated Resident #1's family then showed up and she was confronted by the family asking how come Resident #1 was pushed into the wall. CNA B stated she was unaware of the allegation and had not seen any bruising, redness, scratches, or swelling to the resident's knee as she was very independent and was limited assisted with transfers. CNA B stated she reported to RN C. CNA B stated she was not suspended and had finished her shift.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/27/24 at 2:27 pm, revealed Resident #11, who was alert and oriented to person, place, time and event was Resident #1 roommate. Resident #11 said she never heard any yelling or screaming from Resident #1 about being abused or neglected. Resident #11 stated she overheard Resident #1 telling family yesterday (10/26/24) that they had pushed her into the wall. Resident #11 stated Resident #1 would always complain of left knee pain but never heard her in pain until yesterday (10/26/24) when Resident #1's family arrived. Resident #11 stated the CNAs were helping Resident #1 transfer her into the restroom but didn't see her get pushed into the wall, nor did she complain of any pain or injury at the moment. Resident #11 stated she felt safe at the facility, and no one treated her badly. Resident #11 stated the CNAs were really nice and helped and she has no issues with them. During an interview on 10/30/24 at 11:04 am, the DON stated she had been notified regarding Resident #1's AMA on Saturday 10/27/24. The DON stated she was out on vacation when the allegation occurred and returned to work on 10/30/24. The DON stated she had not received prior allegations against CNA A. The DON stated she was aware of RN C conducting a body assessment on the day of the allegation with no abnormal findings. The DON stated an abuse and neglect in-service had been initiated for all staff. The DON stated CNA A had not been suspended and did not know why they had not been suspended. The DON stated they should have been suspended and was not sure where the Administrator's investigation was at. The DON stated CNA A had finished her shift on 10/26/24. The DON stated failure to suspend CNA A could have placed residents at risk of retaliation against them. The DON stated the abuse coordinator was the Administrator. During an interview on 10/30/24 at 3:33 pm, the Administrator stated he found out about Resident #1's allegation of mistreatment on Sunday 10/27/24. The Administrator stated he was told about Resident #1's knee hitting the wall when she was moved by CNA A. The Administrator stated he started his investigation on 10/27/24 and had not suspended CNA A and did not give reason. The Administrator did not give a potential risk for not suspending CNA A.