

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  03/25/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</b></p> <p>Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, which included injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, which included the state survey agency, in accordance with State law through established procedures for 2 of 3 residents (Residents #2, and #3) reviewed for abuse and neglect.</p> <p>The facility did not report to the State Survey Agency when Residents #2 and #3 eloped from the facility and staff were unaware the resident was missing.</p> <p>This failure could place residents at risk of elopement or injury.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 3/4/25 revealed a [AGE] year-old male who was admitted on [DATE] and readmitted [DATE] with diagnoses of Parkinson's disease with dyskinesia(an age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate), muscle weakness, unspecified dementia, anxiety, repeated falls, restlessness and agitation, altered mental status, unspecified lack of coordination, attention and concentration deficit, cognitive communication deficit.</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 01, indicating his cognition was severely impaired.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's quarterly elopement assessment dated [DATE] revealed that the resident ambulated independently or with the use of a device. The resident frequently requested to go home and was severely impaired, as he never or rarely made decisions. He had a history of restless behavior. He had been residing in the facility for a year or more. The assessment indicated that he did not recognize stop lights or signs and was unaware of necessary precautions when crossing streets. Although he was able to state his name, he did not know the location of his current residence. He was able to recognize his physical needs.</p> <p>Record review of Resident #2's care plan dated 2/8/24 revealed a focus area for elopement risk/wanderer related to resident wanders aimlessly with interventions that included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books.</p> <p>Record review of Resident #2's progress note written by LVN G dated 2/26/25 revealed at approximately 8:08 pm resident was found outside of the facility with another resident. Resident was brought back to the facility and given a head-to-toe assessment. Resident had no signs of injury and was put to bed. vital signs within normal limit. Respirations even and unlabored. DON notified.</p> <p>Resident #3</p> <p>Record review of resident #3's face sheet dated 3/4/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of speech and language deficits, cognitive communication deficit, dementia, anxiety, and paranoid schizophrenia.</p> <p>Record review of resident #3's quarterly MDS dated [DATE] revealed his cognition was moderately impaired, there was no BIMS score noted.</p> <p>Record review of resident #3's last quarterly elopement risk assessment dated [DATE] revealed that he ambulated independently or with the use of a device. His adjustment to the facility was marked by a confused expression when completing tasks. His cognitive skills were severely impaired. his behavior was noted as restlessness. He had been residing in the facility for one year or more. The assessment indicated that he did not recognize stop lights and did not know the precautions to take when crossing streets. Although he was able to state his name, he did not know the location of his current residence and did not recognize his physical needs.</p> <p>Record review of resident #3's progress note written by LVN F dated 2/26/25 revealed at around 8:08 pm resident was found wondering[sic] outside with another resident. Resident was brought back in, full head to toe assessment done, no visible injuries noted. vital signs within normal limit and respiration even and labored. Notified DON.</p> <p>Timeline based on evidence of video reviewed by the Surveyor: (total of 13 minutes from the time Resident #2 and #3 were seen walking out the front door and taken back inside the facility).</p> <p>2/26/25 at approximately 7:30 PM- CNA E had last seen Resident #2 and Resident #3 walking down the hallway and did not observe any signs of agitation/distress. (per CNA E interview).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/26/25 at 7:51 PM- Nurse station footage: Resident #2 and Resident #3 were walking towards the front door. A lab personnel passed by and opened the door for visitors. Both residents were seen crossing the first set of doors.</p> <p>2/26/25 at 7:52 PM - Nurse station footage: Resident #2 and Resident #3 exit the front door. A lab personnel was noted walking back in.</p> <p>2/26/25 at 7:53 PM- Camera from outside: captured Resident #2 and Resident #3 walking out the front door with a visitor holding the door open for them. Resident #2 had his walker, and both were wearing appropriate clothes and shoes. They both walk toward the left side of the building. Resident #2's walker appeared to get stuck in a dirt area, and the visitors assisted with Resident #2's walker.</p> <p>2/26/25 at 7:53 PM - Camera from outside: The visitor walked away from the Resident #2 and Resident #3, and they were no longer visible on camera.</p> <p>2/26/25 between 7:53 pm- 8:06 pm- Dietary Aide D identified Resident #2 and Resident #3 who were found 100-150 feet from the facility still within the premises. (per Dietary Aide D's interview).</p> <p>2/26/25 at 8:07 PM - 8:08 PM - Both residents were assisted back into the facility.</p> <p>During an interview and observation on 3/4/25 at 7:53 pm, CNA E stated that on 2/26/25 she was the assigned CNA for Resident #3. CNA E stated she had last seen Resident #2 and Resident #3 before her lunch break at around 7:30 pm. They were observed by CNA E walking down the 400 hall together, with no agitation or distress observed. CNA E stated Resident #2 and Resident #3 wandered and walked around the facility and tended to walk together; and Resident #3, who is severely cognitive impaired, followed Resident #2. CNA E stated she did not hear any exit door alarms go off. CNA E stated when her break was over around 8:00 pm she had noticed staff walking towards the front door and observed Resident #2 and Resident #3 being assisted back into the facility through the front door. CNA E traced Resident #2 and Resident #3's steps, it appears they took during their elopement, with the Surveyor. CNA E and the Surveyor walked approximately 100 feet from the facility's front door, and no hazardous materials were noted on the concrete floor, there was good light due to light posts noted approximately 20 feet from where Resident #2 and Resident #3 were found.</p> <p>During an interview on 3/5/25 at 9:28 am, the NP stated he had been notified of Resident #2 and #3's elopements. The NP stated they were brought back into the facility and were safe. The NP stated he emphasized observations on residents and was told they were provided. The NP stated there were risks of falls and injuries but did not voice concerns due to how quickly the facility responded.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/5/25 at 9:54 am, the DON stated that on 2/26/25 she received a text message from the Maintenance Director at 8:22 PM, informing her that two residents (Resident #2 and Resident #3) had been seen outside the facility by the flagpole approximately 100 feet from the front door. The DON stated she made her way to the facility and by the time she arrived, Dietary Aide D had already brought them back inside, and both residents were assessed with no injuries noted. The DON stated she notified the Administrator, and he took over the investigation. The DON stated she was later notified that the residents had exited the facility after a lab technician inadvertently held the front door open for them. The DON stated the next morning (2/27/25), Maintenance Director had reviewed security footage confirming that a lab technician and visitor had let Resident #2 and Resident #3 outside. The DON stated as a corrective action, the facility conducted an in-service training emphasizing that door codes should not be shared with any outside entities, including providers or family members. The DON stated the facility changed the door codes to prevent future unauthorized exits. The DON stated that based on policy, the facility should have reported the incident, but reporting decisions were ultimately made by the Administrator.</p> <p>During an interview on 3/5/25 at 2:53 pm, the Administrator stated the DON informed him that Residents #2 and #3 had been found outside but had already returned to the facility. The Administrator stated the following morning, video footage revealed that a lab technician had opened the door for visitors, who then held it open, allowing Residents #2 and #3 to exit. The Administrator stated he contacted the lab facility to express concerns, and the lab stated they would address the issue with their staff. The Administrator stated the Maintenance Director was instructed to change all door codes, and in-service training was conducted. This incident was also not reported to the SO (State Office), as the residents had remained on the premises.</p> <p>During an interview on 3/25/25 at 12:36 pm, the Visitor stated she had received a call from the Administrator, but did not remember the date and/or time, who inquired about the incident and educated her on the importance of safety for all residents. She stated the Administrator advised her not to allow residents to exit the facility, as it could pose a danger to them</p> <p>During a follow up interview on 3/25/25 at 12:38 pm, the DON stated that because both residents (Residents #2 and #3) were ambulatory and tended to wander near the first set of front doors, they were flagged as an attempted elopement risk to increase supervision. There had been no reported attempts by either resident to actually open the door.</p> <p>During a follow up interview on 3/25/25 at 2:18 pm, the Administrator stated that the residents (Resident #2 and #3) were not safe to be outside unsupervised. The Administrator stated that the situation was not considered neglect, as the residents were located within the premises in a short period of time and were found unharmed.</p> <p>Record review of the facility's Elopements and Wandering Residents policy, dated 04/2022, revealed 4. Procedure for locating a missing resident: H. Appropriate reporting requirements to the State Survey agency shall be conducted.</p> <p>Record review of the facility's Abuse, Neglect, and Exploitation dated 07/2022 revealed in part A. The facility will have written procedures that include:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43871</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 2 (Residents #2, and #3) of 3 residents reviewed for accidents and supervision.</p> <p>The facility failed to provide supervision to prevent accidents for Residents #2 and #3 who exited the facility thru the front door on 2/26/25.</p> <p>The noncompliance was identified as PNC . The IJ began on 2/26/25 and ended 2/27/25. The facility had corrected the noncompliance before the survey began.</p> <p>These failures placed residents at risk of injuries.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet dated 3/4/25 revealed a [AGE] year-old male who was admitted on [DATE] and readmitted [DATE] with diagnoses of Parkinson's disease with dyskinesia (an age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate with involuntary movements of face, arms, or leg), muscle weakness, unspecified dementia, anxiety, repeated falls, restlessness and agitation, altered mental status, unspecified lack of coordination, attention and concentration deficit, cognitive communication deficit.</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 01, indicating his cognition was severely impaired.</p> <p>Record review of Resident #2's quarterly elopement assessment dated [DATE] revealed that the resident ambulated independently or with the use of a device. The resident frequently requested to go home and was severely impaired , as he never or rarely made decisions. He had a history of restless and wandering behavior. He had been residing in the facility for a year or more. The assessment indicated that he did not recognize stop lights or signs and was unaware of necessary precautions when crossing streets. Although he was able to state his name, he did not know the location of his current residence. He was able to recognize his physical needs.</p> <p>Record review of Resident #2's care plan dated 2/8/24 revealed a focus area for elopement risk/wanderer related to resident wanders aimlessly with interventions that included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books.</p> <p>Record review of Resident #2's progress note written by LVN G dated 2/26/25 revealed at approximately 8:08 pm resident was found outside of the facility with another resident. Resident was brought back to the facility and given a head-to-toe assessment. Resident had no signs of injury and was put to bed. vital signs within normal limit. Respirations even and unlabored. DON notified.</p> <p>Resident #3</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's face sheet dated 3/4/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of speech and language deficits, cognitive communication deficit, dementia, anxiety, and paranoid schizophrenia.</p> <p>Record review of Resident #3's quarterly MDS dated [DATE] revealed his cognition was moderately impaired, there was no BIMS score noted .</p> <p>Record review of Resident #3's last quarterly elopement risk assessment dated [DATE] revealed that he ambulated independently or with the use of a device. His adjustment to the facility was marked by a confused expression when completing tasks. His cognitive skills were severely impaired. His behavior was noted as restlessness and wandering. He had been residing in the facility for one year or more. The assessment indicated that he did not recognize stop lights and did not know the precautions to take when crossing streets. Although he was able to state his name, he did not know the location of his current residence and did not recognize his physical needs.</p> <p>Record review of Resident #3's progress note written by LVN F dated 2/26/25 revealed at around 8:08 pm resident was found wondering [sic] outside with another resident. Resident was brought back in, full head to toe assessment done, no visible injuries noted. vital signs within normal limit and respiration even and unlabored . Notified DON.</p> <p>Observation of facility video revealed a total of 13 minutes from the time Residents #2 and #3 were seen walking out the front door to the time they were taken back inside the facility:</p> <p>2/26/25 at 7:51 PM- Nurse station footage: Resident #2 and Resident #3 were walking towards the front door. A lab personnel passed by and opened the door for visitors. Both residents were seen crossing the first set of doors.</p> <p>2/26/25 at 7:52 PM - Nurse station footage: Resident #2 and Resident #3 exit the front door. A lab personnel was noted walking back in.</p> <p>2/26/25 at 7:53 PM- Camera from outside: captured Resident #2 and Resident #3 walking out the front door with a visitor holding the door open for them. Resident #2 had his walker, and both were wearing appropriate clothes and shoes. They both walked toward the left side of the building. Resident #2's walker appeared to get stuck in a dirt area, and the visitors assisted with Resident #2's walker .</p> <p>2/26/25 at 7:53 PM - Camera from outside: The visitor walked away from Resident #2 and Resident #3, and they were no longer visible on camera.</p> <p>2/26/25 at 8:07 PM - 8:08 PM - Both residents were assisted back into the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 3/4/25 at 7:53 pm, CNA E stated that on 2/26/25 she was the assigned CNA for Resident #3. CNA E stated she had last seen Resident #2 and Resident #3 before her lunch break at around 7:30 pm. They were observed by CNA E walking down the 400 hall together, with no agitation or distress observed. CNA E stated Resident #2 and Resident #3 wandered and walked around the facility and tended to walk together; and Resident #3, who is severely cognitive impaired, followed Resident #2. CNA E stated she did not hear any exit door alarms go off. CNA E stated when her break was over around 8:00 pm she had noticed staff walking towards the front door and observed Resident #2 and Resident #3 being assisted back into the facility through the front door. CNA E traced the steps it appears Resident #2 and Resident #3 took during their elopement, with the Surveyor. CNA E and the Surveyor walked approximately 100 feet from the facility's front door, and no hazardous materials were noted on the concrete floor , there was good light due to light posts noted approximately 20 feet from where Resident #2 and Resident #3 were found.</p> <p>During an observation and interview on 3/4/25 at 8:48 pm, Resident #2 was observed sitting at the edge of his bed, wearing appropriate shoes. He was alert and oriented to person only (AOx1) and appeared pleasantly confused, with no recollection of the elopement. He was unable to answer questions and showed no signs of distress.</p> <p>During an observation and attempted interview on 3/5/25 at 9:05 am, revealed Resident #3 was observed walking down the 400 hall toward the door before turning around and walking back up the hallway. He appeared very confused and did not respond to any questions. Two CNAs were noted by the computer station in the middle of the hallway, observing him. No signs of distress were observed.</p> <p>During an interview on 3/5/25 at 9:54 am, the DON stated that on 2/26/25 she received a text message from the Maintenance Director at 8:22 PM, informing her that two residents (Resident #2 and Resident #3) had been seen outside the facility. The DON stated she made her way to the facility and by the time she arrived, Dietary Aide D had already brought them back inside, and both residents were assessed with no injuries noted. The DON stated she notified the Administrator, and he took over the investigation. The DON stated she was later notified that the residents had exited the facility after a lab technician inadvertently held the front door open for them. The DON stated the next morning (2/27/25), the Maintenance Director reviewed security footage confirming that a lab technician and visitor had let Resident #2 and Resident #3 outside. The DON stated as a corrective action, the facility conducted an in-service training emphasizing that door codes should not be shared with any outside entities, including providers or family members. The DON stated the facility changed the door codes to prevent future unauthorized exits. The DON stated that both residents (Resident #2 and Resident #3) did not have any safety awareness and would have been at risk for falls and increased supervision was implemented.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/5/25 at 10:33 am, the Maintenance Director stated he had been notified of Residents #2 and #3 elopement on 2/26/25 after hours. The Maintenance Director stated the following day on 2/27/25 he reviewed the camera and noticed that a lab technician had opened the door for two visitors around 7:53 PM after exiting the restroom. The Maintenance Director stated she inadvertently held the door open, allowing the visitors and Residents #2 and #3 to leave. The Maintenance Director stated he also reviewed footage from the front camera, which showed one of the visitors assisting Resident #2 with his walker, as it had gotten stuck. After a few minutes, they (visitors) walked away. The Maintenance Director stated he checked the alarm system and doors and confirmed there were no issues identified. The Maintenance Director stated in response to the incident, the facility conducted in-services on elopement response procedures, specifically regarding alarm door activations, and updated the door codes to prevent future unauthorized exits.</p> <p>During an interview on 3/5/25 at 12:45 pm, Dietary Aide D stated that on the day of the incident (2/26/25), she had finished work around 8:05-8:10 PM. Dietary Aide D stated as she was driving off, she noticed Residents #2 and #3 near the flagpole in front of the premises (approximately 100-150 feet away from the front door). Dietary Aide D stated she immediately called Dietary Aide C, who was driving ahead of her, to confirm if she had seen them as well. Dietary Aide D stated Dietary Aide C did confirm seeing them, and she asked her to return to the facility to alert the staff while she stayed with the residents. Dietary Aide D stated it took a while to convince both residents to get into the car. Dietary Aide D stated that both residents appeared confused, with Resident #3 being the most confused of the two. Dietary Aide D stated she had recently attended an in-service about changing the door codes and was instructed not to share them.</p> <p>During an interview with a Visitor on 3/25/25 at 12:36 pm she said she had received a call from the administrator, who inquired about the incident and educated her on the importance of safety for all residents. The administrator advised her not to allow residents to exit the facility, as it could pose a danger to them.</p> <p>During an interview on 3/5/25 at 2:53 pm, the Administrator stated the DON notified him that Residents #2 and #3 had been found outside but had already returned to the facility. The Administrator stated the following morning, video footage revealed that a lab technician had opened the door for visitors, who then held it open, allowing Residents #2 and #3 to exit. The Administrator stated he contacted the lab facility to express concerns, and the lab stated they would address the issue with their staff. The Administrator stated the Maintenance Director was instructed to change all door codes, and in-service training was conducted.</p> <p>During a follow up interview on 3/25/25 at 12:38 pm, the DON stated that because both residents (Residents #2 and #3) were ambulatory and tended to wander near the first set of front doors, they were flagged as an attempted elopement risk in order to increase supervision . There had been no reported attempts by either resident to actually open the door.</p> <p>Record review of undated Elopement/Missing Resident policy revealed in part To provide an organized procedure to search for an eloped or missing resident. Staff will respond in timely and organized manner to search for a resident who has eloped or is missing. A- when a resident is noted missing from the room or unit, the staff shall inform the DON of the charge nurse in his/her absence, that we have an elopement or missing resident, the residents name, and the room number.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering on 3/4/25.</p> <p>Observations:</p> <p>During an observation on 3/4/25 at 12:45 pm, there was a laminated sign on the front door that reflected: please do not open the door for anyone that is not in your party, as it may be a resident noted in red letters and highlighted in yellow for attention.</p> <p>Observation on 3/4/25 at 8:48 pm, revealed CNA I pushed the front door, triggering the alarm. Four staff members at the nurses' station were observed getting up to respond.</p> <p>Interviews from 3/4/25-3/7/25:</p> <p>LVN A, CNA B, Dietary Aide D, CNA E, CNA I, CNA J, the Receptionist and Activities Director confirmed receiving in-services regarding door codes being changed with reinforcement of not providing the code to any outside entity and elopement policy that included increased supervision for high risk elopement residents.</p> <p>Record review:</p> <p>In-service to all staff: elopement policy (that included supervision) dated 2/26/25.</p> <p>In-service to all staff: door codes dated 2/26/25- do not provide door code to anyone this includes lab techs, pharmacy, families, outside providers, etc., please notify Administrator, DON and ADON if code has been jeopardized.</p>

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  03/25/2025
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43871</p> <p>Based on observation, interview, and record review the facility failed to ensure nurse aides were able to demonstrate competency in skills and techniques to care for residents' needs for 1 (Resident #11) of 3 residents reviewed for accidents and supervision.</p> <p>CNA B failed to place brakes on the mechanical lift when lifting Resident #11 from her bed and CNA J failed to place brakes on the wheelchair when the resident was lowered down.</p> <p>These failures placed residents at risk of injuries.</p> <p>The findings include:</p> <p>Record review of Resident #11's face sheet dated 3/7/25 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of dementia, muscle weakness, and cognitive communication deficit.</p> <p>Record review of Resident #11's quarterly MDS assessment dated [DATE] revealed her cognition was severely impaired and she was dependent on staff for transfers .</p> <p>Record review of Resident #11's care plan dated 6/5/24 revealed a focus area for resident has an ADL self-care performance deficit with interventions that included requires mechanical lift with 2 staff assistance for transfers.</p> <p>During an observation and attempted interview on 3/7/25 at 9:06 am, Resident #11 was in bed with a sling (device used for safe transfers) under her and did not respond to verbal questions. CNA B and CNA J washed their hands then assisted in transferring her from the bed to a wheelchair using a mechanical lift. CNA J positioned the sling, and CNA B operated the mechanical lift. CNA B lifted Resident #11 from the bed without engaging the mechanical lift breaks. CNA J did not engage the brakes on the wheelchair before positioning Resident #11 as she was being lowered down. The transfer was completed without incident or signs of distress.</p> <p>During a joint interview on 3/7/25 at 9:12 am, CNA J and CNA B stated they last received training on mechanical lift transfers last year (2024) from the previous PT . CNA J stated that wheelchair brakes should be engaged before seating the resident but admitted she forgot, stating that the potential risk was movement and possible accidents. CNA B said that the mechanical lift brakes were only engaged when lowering a resident, not when lifting, as the base was positioned under the bed. CNA B stated that due to the resident's petite size, the lift did not move, minimizing the perceived risk.</p> <p>During an interview on 3/7/25 at 11:03 am, the DON stated PT was responsible for mechanical lift training. The DON stated she expected the brakes to be engaged when lifting a resident from bed to prevent movement and the wheelchair brakes should be engaged before lowering the resident into the wheelchair to prevent falls due to chair movement.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/7/25 at 1:12 pm, the DOR stated that the rehabilitation therapy department recently took over responsibility for mechanical lift transfers, which were previously managed by the former DOR. She stated CNAs were expected to secure the brakes on the lift before lifting the resident and secure the wheelchair brakes before lowering them to prevent movement. She also noted that failing to open the legs of the mechanical lift could cause it to rock sideways and lose balance, creating a safety risk. She was unsure how often training on mechanical lift transfers was conducted.</p> <p>During an interview on 3/7/25 at 1:36 pm, the Administrator stated that both nursing and therapy were responsible for conducting mechanical lift transfer training upon hire and annually. He stated the mechanical lift transfers require two-person assistance but referred specific details to the nursing and therapy departments.</p> <p>Record review of the facility's Safe Resident Handling/Transfers policy not dated revealed in part 15. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device.</p> <p>Record review of mechanical lifts owner's manual, not dated, provided by the facility revealed it did not specify when to engage brakes during a transfer.</p>		