

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Center at Zaragoza, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12660 Pebble Hills Blvd. El Paso, TX 79938	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview and record review the facility failed to respect a resident's right to personal privacy during personal care for 2 of 7 residents (Resident #4 and Resident #8) reviewed for respect and dignity.</p> <p>Staff Coordinator did not close the room binds when providing patient care for Resident #4 during weighing Resident #4.</p> <p>CNA A left Resident #8's room leaving the door open exposing Patient #8's brief and private area.</p> <p>These failures could place residents at risk of diminished quality of life, lack of privacy, and lack of dignity.</p> <p>Finding included:</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 01/22/25, revealed, admission on 12/17/24 to the facility.</p> <p>Record review of Resident #4's hospital history and physical dated 12/11/24, revealed, an [AGE] year-old female diagnosed with</p> <p>Diabetes Type 2 and right leg pain due to a fall.</p> <p>Record review of Resident #4's admission MDS dated [DATE], revealed, moderate impaired cognition BIMS score of 11 to be able to recall or make daily decisions. ADLs revealed dependent (staff does all the work) for roll left or right, sit to lying, lying to sitting, toileting, showers, dressing lower body. diagnosed with Ankylosing spondylitis of thoracic region (a type of arthritis that causes inflammation in the thoracic spine, or middle of the back).</p> <p>Record review of Resident #4's care plan dated 12/26/24, revealed, decline in mood state. Patients' mood will remain stable or improve.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 01/17/25 at 2:53 PM, with LVN C, she stated she saw state agency observing Staffing Coordinator conducting resident care with the blinds open it and immediately walked into Resident #4's room and closed the binds. LVN C stated the Staff Coordinator should have closed the binds and not left them open because everyone could see what was being done to</p> <p>Resident #4 during patient care. LVN C stated there was no privacy for Patient #4.</p> <p>During an interview on 01/17/25 at 3:20 PM, with Staffing Coordinator, stated he did not close the binds to Resident #4's room when he was providing patient care. Staffing Coordinator stated he did need to close the blinds or window curtains for the Residents dignity.</p> <p>Resident #8</p> <p>Record review of Resident #8's face sheet dated 01/22/25, revealed, admission on 12/07/24, and re-admission on 01/09/25 to the facility.</p> <p>Record review of Resident #8's hospital history and physical dated 12/28/24, revealed, a [AGE] year-old female diagnosed with Dementia, Fibromyalgia (a chronic condition that causes pain and tenderness in the muscles and soft tissues throughout the body), cervical intervertebral disc herniation (occurs when the soft center of a spinal disc pushes out through a tear in the disc's outer ring).</p> <p>Record review of Resident #8's MDS dated [DATE], revealed, there was no BIMS score completed to assess cognition nor the Residents functional ability. Diagnoses revealed muscle weakness (e muscles lack strength and may not move as easily), muscle wasting (the loss of muscle mass and strength), and lack of coordination. Resident #8 was coded for always incontinent for urinary and frequently incontinent for bowel.</p> <p>Record review of Resident #8's Comprehensive Care Plan dated 12/07/24, revealed, potential/actual decline in ADLs. Provide assistance as needed with grooming, bathing, and personal hygiene and per patients' preferences. Incontinence with bowel/bladder. Check frequently and assist with toileting as needed. Provide peri care after each episode and apply barrier cream as needed. Patient #8 has impaired mobility secondary to weakness and debility.</p> <p>Record review of Resident #8's baseline care plan dated 01/09/25, revealed, dependent (Where nursing staff does all the work) for bed mobility and transfers. Baseline care plan does not indicate any specifics on incontinence care or toileting for Resident #8.</p> <p>Observation on 01/17/25 at 2:45 PM, revealed, CNA A coming out of Resident #8's room heading to get incontinent care items while Resident #8's door remained open exposing Resident #8's brief and private area.</p> <p>During an interview on 01/17/25 at 3:58 PM, with CNA A, she stated she was going to change Resident #8. CNA A stated she left the room to go get the incontinent care items (briefs and pads) that she was going to need for Resident #8. CNA A stated anytime incontinent care was to be performed the curtain or door had to be closed or the Patient covered up to provide privacy. CNA A stated there was no risk for the patient other than the privacy issue. CNA A stated she would be embarrassed if the curtain or door was left open exposing her brief and or private area.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/21/25 at 1:38 PM, with NP, he stated when performing the incontinence care the facility staff should be providing privacy for the patient. NP stated it was a moral issue and it would be a HIPPA but with the patient's body.</p> <p>During an interview on 01/21/25 at 2:51 PM, with the DON, she stated nursing staff were trained on incontinence care and privacy was number one and patients should feel safe and comfortable with care.</p> <p>Record review of the facility Patient Rights: Planning and Implementing Care dated 02/08/21, revealed, The Centers honor our patients' rights to: Equal access to quality of care. The policy given does not indicate anything regarding resident rights for privacy or dignity.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on interview and record review the facility failed to ensure that the assessment accurately reflected the patient's status for 1 (Resident #2) of 4 residents reviewed for accuracy of MDS assessment.</p> <p>Resident #2's admission MDS did not accurately reflect the patients' use of bed rails (enablers).</p> <p>This deficient practice could place residents at risk of not receiving adequate care.</p> <p>Findings included:</p> <p>Record review of Resident #2's hospital history and physical dated 11/22/24, revealed, an [AGE] year-old female diagnosed with anxiety and osteoporosis.</p> <p>Record review of Resident #2's face sheet dated 01/21/25, revealed, admission on 12/04/24 to the facility.</p> <p>Record review of Resident #2's order dated 12/04/24, revealed, Enablers - upper to allow use of bed controls and assist with bed mobility.</p> <p>Record review of Resident #2's Assistive Transfer Device Consent dated 12/04/24, revealed, Assistive Transfer Device: The facility utilizes fully functional beds that come equipped with transfer bars. The benefits of these bars are - 1. Independent control of bed positions. 2. Assist with transferring and reposition. The risks are - 1. Falling. 2. Entrapment. It was signed by Patient/Guardian, nurse, and Patient #2.</p> <p>Record review of Resident #2's baseline care plan dated 12/04/24, revealed, there was no focus area for bed rail (enables) use.</p> <p>Record review of Resident #2's MDS dated [DATE], revealed, little to no cognitive impairment BIMS score of 13 to be able to recall or make daily decisions. ADLs were dependent (staff does all the work) for toileting, roll lift and right, and sit to lying while in bed.</p> <p>Patient #2 was not coded for bed rail (enabler) in Section P - Restraints and Alarms of the MDS.</p> <p>Record review of Resident #2's comprehensive care plan dated 01/21/25, revealed there was no focus area for bed rails (enablers).</p> <p>During an interview 01/17/25 at 2:04 PM, with the DON, she stated she had observed Resident #2's MDS and did not see it was coded for bed rails. The DON stated she was new to nursing home and needed to review with the MDS department regarding the risks but would think there would be a risk.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/21/25 at 11:47 AM, with the MDS Coordinator, she stated the MDS department and nurses were responsible for generating the MDSs and making sure they were correct and accurate. The MDS Coordinator stated Patient #2 was not coded for bed rails (enabler) on the MDS but does use them to assist staff and herself. The MDS Coordinator stated she did not know what the risk would be not having it coded on the MDS.</p> <p>Record review of the facility MDS policy dated 03/14/24, revealed, Policy - It was the policy of this facility that MDS assessments, discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and appropriate assessment will be transmitted to CMS.</p> <p>All staff members will be responsible for completion of the MDS and transmission processes in accordance with the MDS RAI instruction manual.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>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 1 of 7 residents (Resident #2) reviewed for care plans.</p> <p>The facility failed to implement a comprehensive person-centered care plan for Resident #2's use of bed rails (enablers).</p> <p>The facility failed to implement a comprehensive person-centered care plan for CNA B not being able to work with Resident #2 due to an facility self-reported incident.</p> <p>This deficient practice 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.</p> <p>Findings include:</p> <p>Record review of Resident #2's hospital history and physical dated 11/22/24, revealed, an [AGE] year-old female diagnosed with anxiety and osteoporosis.</p> <p>Record review of Resident #2's face sheet dated 01/21/25, revealed, admission on 12/04/24 to the facility.</p> <p>Record review of Resident #2's order dated 12/04/24, revealed, Enablers - upper to allow use of bed controls and assist with bed mobility.</p> <p>Record review of Resident #2's Assistive Transfer Device Consent dated 12/04/24, revealed, Assistive Transfer Device: The facility utilizes fully functional beds that come equipped with transfer bars. The benefits of these bars are - 1. Independent control of bed positions. 2. Assist with transferring and reposition. The risks are - 1. Falling. 2. Entrapment. It was signed by Patient/Guardian, nurse, and Patient #2.</p> <p>Record review of Resident #2's baseline care plan dated 12/04/24, revealed, there was no focus area for bed rail (enablers) use.</p> <p>Record review of Resident #2's MDS dated [DATE], revealed, little to no cognitive impairment BIMS score of 13 to be able to recall or make daily decisions. ADLs were dependent (staff does all the work) for toileting, roll lift and right, and sit to lying while in bed. Patient #2 was not coded for bed rail (enabler) in Section P - Restraints and Alarms of the MDS.</p> <p>Record review of Patient #2's comprehensive care plan dated 01/21/25, revealed there was no focus area for bed rails (enablers).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility self-report dated 12/11/24, revealed during incontinent care on 12/10/24 Patient #2 hit her right wrist on a bed rail (enabler) when trying to assist CNA A who was being rough during incontinent care. LVN E noted Resident #2's right wrist to be swollen and tender to touch. CNA A was placed on suspension, the physician/DON/Administrator/family were notified, x-rays were ordered stat of Resident #2's wrist revealing no fractures, CNA A was not allowed to work with Resident #2 anymore, and facility self-reported to state agency. Facility summary of investigation revealed resident interviews were conducted with no findings in relation to occurrence. Facility investigation was unconfirmed.</p> <p>During an interview 01/17/25 at 2:04 PM, with the DON, she stated CNA A was conducting incontinent care when Resident #2 was trying to assist CNA A and Resident #2 hurt her herself and could not remember which hand it was. The DON stated x-rays were ordered stat and revealed no fractures. The DON stated CNA A was suspended until the facility investigation was complete and in-services on Abuse and Customer service were given to all the staff and CNA A. The DON stated CNA A was not to be assigned to Resident #2 and should have been care planned. The DON stated the risk was that the CNA A could end up assigned to Resident #2. The DON stated she had observed Resident #2's care plan and did not see any focus area or intervention for the bed rail (enabler) use. The DON stated there would be a risk of the patient getting hurt and nursing staff not knowing how to work with the resident. The DON stated all the nursing staff were responsible for the care plan.</p> <p>During an interview on 01/21/25 at 11:47 AM, with the MDS Coordinator and Administrator, the MDS Coordinator stated the MDS department and nurses were responsible for generating the care plans and making sure they were correct and accurate. The MDS Coordinator stated there was no focus area nor interventions on the care plan for Resident #2 for use of bed rails (enabler). The Administrator stated she did not see a focus area nor interventions for Resident #2 on the care plan. The MDS Coordinator stated it should have been care planned for CNA A to not be working with Resident #2. The MDS Coordinator stated the risk of not care planning it would be not identifying the issues and interventions related to the resident.</p> <p>During an interview on 01/21/25 at 1:38 PM, with NP, he stated that patients using bed rails (enabler) needed to have it care planned. The NP stated the risk of not having it care planned would depend on the situation of the patient.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on the observation, interview, and record review the facility failed to ensure that the patients environment remains free of accidents hazards as is possible and each patient received adequate supervision to prevent accidents for 1 (Resident #4) of 4 residents reviewed for accidents.</p> <p>Staff Coordinator was weighing Resident #4 in her room by using a mechanical lift to lift Resident #4 by himself.</p> <p>Staff Coordinator did not lock the mechanical lift brakes when lifting Patient #4 up in the air as he was weighing and then moved the mechanical lift upwards to re-position Patient #4.</p> <p>This failure could affect residents who required the use of a mechanical lift for transfers, by placing them at risk of improper transfers resulting in injury.</p> <p>Findings include:</p> <p>Record review of Resident #4's face sheet dated 01/22/25, revealed, admission on 12/17/24 to the facility.</p> <p>Record review of Resident #4's hospital history and physical dated 12/11/24, revealed, an [AGE] year-old female diagnosed with Diabetes Type 2 and right leg pain due to a fall.</p> <p>Record review of Resident #4's admission MDS dated [DATE], revealed, moderate impaired cognition BIMS score of 11 to be able to recall or make daily decisions. ADLs revealed dependent (staff does all the work) for roll left or right, sit to lying, lying to sitting, toileting, showers, dressing lower body. diagnosed with Ankylosing spondylitis of thoracic region (a type of arthritis that causes inflammation in the thoracic spine, or middle of the back).</p> <p>Record review of Resident #4's baseline care plan dated 12/17/24, revealed, bed mobility - physical assist of two persons and transfer was total dependent. History of falls.</p> <p>Record review of Resident #4's care plan dated 12/26/24, revealed, ADLs related to self-care and deficits and decreased functional mobility was added on 01/20/25 during state agency's visit. Hoyer lift with two aides was also added on 01/20/25 during state agency's visit as there was no ADLs noted before visit date.</p> <p>Record review of facility Weights Form dated 01/15/25, revealed, name of Resident #4 and type of transfer which was hoyer.</p> <p>Observation and interview on 01/17/25 at 2:53 PM, LVN C stated she saw state agency seeing it and immediately walked into</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4's room and then came out of the room. LVN C stated the Staffing Coordinator was in the room with Resident #4 and was using the mechanical lift. LVN C stated when using the mechanical lift it required two staff to operate it. LVN C stated this was for the safety of the resident. LVN C stated the mechanical lift brakes where to be applied before lifting Resident #4 into the air. LVN C stated this was for safety reason. LVN C stated the mechanical lift could slide back and forth causing an injury to both staff and patient.</p> <p>During an interview on 01/17/25 at 3:20 PM, with Staffing Coordinator, he stated he was trained on transfers and using the hoyer lifts. Staffing Coordinator stated he was going to take Patient #4's weights but was not going to transfer her. Staffing Coordinator stated he was alone when he performed the weighing. Staffing Coordinator stated using the mechanical lift required two staff when operating it. Staffing Coordinator stated his Weights Form notified him of what transfer Patient #4 was and other patients. Staffing Coordinator stated he did not apply the hoyer lift brakes and he should have. Staffing Coordinator stated the risk for using the hoyer lift with one person and not applying the brakes was a fall and or injury to both the patient or the staff.</p> <p>During an interview on 01/21/25 at 2:51 PM, with the DON, she stated facility staff have been trained on hoyer transfers. The DON stated when using the mechanical lift it did require to have two staff to operate it. The DON stated this was in cases something went wrong. The DON stated the brakes had to be locked before lifting the patient up. The DON stated the risk would be an injury to both the patient and staff.</p> <p>Record review of the facility Mechanical Lifts Policy dated 02/01/23, revealed, Policy - The Centers utilize mechanical lifts when appropriate to ensure safe patient handling during transfers and employee safety when providing patient care. Direct care staff will receive training upon hire and as needed for proper preparation of the patient, equipment, and environment during utilization of mechanical lifts.</p> <p>2 staff members are required for utilization of the lift.</p> <p>On 01/17/25 at 3:48 PM, a text message was sent to the Administrator requesting an Accidents Policy and nothing was provided to state agency. At the end of exit state agency asked if the facility had anything to provide and nothing else was provided.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure patients who were incontinent received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #3) of 2 residents reviewed for incontinent care/Foley catheter care.</p> <p>The facility failed to empty Resident #3's catheter before it got full backing up into the tubing.</p> <p>These failures placed residents at risk for infection and hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet dated 01/22/25, revealed, admission on 01/16/25 to the facility.</p> <p>Record review of Resident #3's facility history and physical dated 01/17/25, revealed a [AGE] year-old female diagnosed with Diabetes, right ankle displaced Tri-malleolar fracture (a rare, but severe break in the ankle that affects three parts of the ankle bone).</p> <p>Record review of Resident #3's admission MDS dated [DATE], revealed, an intact cogitation BIMS score of 15 to be able to recall and make daily decisions. Patient #3 was always incontinent. MDS did not have the functional abilities coded. Was coded for indwelling catheter.</p> <p>Record review of Resident #3's Order dated 01/16/25, revealed, foley catheter care q shift and as needed. Every shift for foley catheter maintenance.</p> <p>Record review of Resident #3's care plan dated 01/16/25, revealed, incontinent with bowel/bladder. Keep call light within reach and remind Patient #3 to call for assistance. Resident #3 had catheter. Change foley catheter as ordered by physician and as needed.</p> <p>Observation and interview on 01/17/25 at 3:01 PM, with Resident #3, it was observed Resident #3 to be lying in bed. Catheter bag was hanging off the left side of the bed. The catheter bag was full of a dark brownish colored urine. The tubing was filled with pink colored and cloudy substance that went all the way back towards the patient. Resident #3 stated the nursing staff were draining the catheter bag 3-4 times a day.</p> <p>During an interview on 01/17/25 at 3:58 PM, with CNA A, she stated the CNAs were responsible for checking on the catheter bags at the end of every shift when the bag was drained and then documented. CNA A stated if the catheter bag was too full then they will drain it during the day. CNA A stated if the catheter bag was really full then it could cause reverse back flow, going back into the patient causing an infection. CNA A stated if there was anything in the tube such as blood or its too dirty, they are to be reporting it to the nurse to prevent infection.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/21/25 at 1:38 PM, with NP, he stated cloudy tubing and filled catheter bags should be emptied and should not be full. NP stated this was to avoid a UTI. NP stated if there was sediment in the tubing then it should be reported to the nurse. NP stated full or cloudy tubing and catheter bags should be prevented to prevent back flow into the Patient and bacterial growth.</p> <p>During an interview on 01/21/25 at 2:51 PM, with the DON, she stated the CNAs were responsible for reporting an issue with catheter such as the tubing being full, having sediment, and color. The DON stated it was not okay to have sediment in the tubing and need to notify the nurse. The DON stated the CNAs should be changing out the catheter bags when it gets half ways and should be done with their intentional rounds. The DON stated the risk could be back flow and infection.</p> <p>Record review of the facility Foley Catheter Policy dated 02/08/21, revealed, Purpose - The Centers are dedicated to providing the best care possible to patients who entrust us with their care. Policy - If a patient requires an indwelling catheter, the facility will follow routine foley catheter care orders.</p> <p>Notify DON/ADON of issues.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Center at Zaragoza, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12660 Pebble Hills Blvd. El Paso, TX 79938	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to assess the patient for risk of entrapment from an enabler (bed rail) prior to installation or review the risks prior to installation for 1 (Resident #2) of 4 patients reviewed for enablers (bed rails).</p> <p>Resident #2 did not have a Bed Transfer Bar Evaluation Assessment done to ensure the Enablers (bed rails) were appropriate for the use of Resident #2's needs.</p> <p>This failure could place residents who have bed [NAME] (enablers) at risk of having inappropriate or unnecessary enablers in place increasing their risk of injury.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet dated 01/21/25, revealed, admission on 12/04/24 to the facility.</p> <p>Record review of Resident #2's hospital history and physical dated 11/22/24, revealed, an [AGE] year-old female diagnosed with anxiety and osteoporosis.</p> <p>Record review of Resident #2's MDS dated [DATE], revealed, little to no cognitive impairment BIMS score of 13 to be able to recall or make daily decisions. ADLs were dependent (staff does all the work) for toileting, roll lift and right, and sit to lying while in bed.</p> <p>Patient #2 was not coded for bed rail (enabler) in Section P - Restraints and Alarms of the MDS.</p> <p>Record review of Resident #2's order dated 12/04/24, revealed, Enablers - upper to allow use of bed controls and assist with bed mobility.</p> <p>Record review of Resident #2's baseline care plan dated 12/04/24, revealed, there was no focus area for bed rail (enables) use.</p> <p>Record review of Resident #2's comprehensive care plan dated 01/21/25, revealed there was no focus area for bed rails (enablers).</p> <p>Record review of Resident #2's Assistive Transfer Device Consent dated 12/04/24, revealed, Assistive Transfer Device: The facility utilizes fully functional beds that come equipped with transfer bars. The benefits of these bars are - 1. Independent control of bed positions. 2. Assist with transferring and reposition. The risks are - 1. Falling. 2. Entrapment. It was signed by Patient/Guardian, nurse, and Patient #2.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Center at Zaragoza, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12660 Pebble Hills Blvd. El Paso, TX 79938	
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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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's Progress Notes generated by LVN D dated 12/10/24, revealed, LVN D went into administrator morning medications when Resident #2 complained of pain to her right wrist. This LVN D attempted to reach over for blanket to further assess and Resident #2 yelled in pain and flinched without touching Resident #2. This LVN D then noted Resident #2 right wrist to be swollen and tender to touch. This LVN D asked Resident #2 how her wrist got hurt and Resident #2 stated it was during incontinence care where she hit her hand on the bar (bed rail (enabler)). X-ray were ordered for right wrist and medicated for pain.</p> <p>- 12/10/24 - Progress Note: X-rays results were negative for any fractures/dislocation to the right hand and wrist.</p> <p>Record review of facility self-report dated 12/11/24, revealed during incontinent care on 12/10/24 Resident #2 hit her right wrist on a bed rail (enabler) when trying to assist CNA A who was being rough during incontinent care. LVN E noted Resident #2's right wrist to be swollen and tender to touch. CNA A was placed on suspension, the physician/DON/Administrator/family were notified, x-rays were ordered stat of Resident #2's wrist revealing no fractures, and facility self-reported to state agency. Facility summary of investigation revealed patient interviews were conducted with no findings in relation to occurrence. Facility investigation was unconfirmed.</p> <p>During an interview on 01/21/25 at 11:05 AM, with the Administrator, she stated she was not able to see or find a Bed/Transfer/Bar Evaluation for Resident #2.</p> <p>During an interview on 01/21/25 at 1:38 PM, with NP, he stated all residents using bed rails (enablers) were required to have an assessment for use of a bed rail (enabler). NP stated if the patient was not strong enough to use them then they were not able to use the bed rails. NP stated not conducting a bed rail assessment would be a risk and would depend on the patient situation.</p> <p>On 01/21/25 at 2:50 PM, the DON, she stated there was no Bed/Transfer/Bar Assessment policy.</p> <p>During an interview on 01/21/25 at 2:55 PM, with the DON, she stated the purpose of a Bed/Transfer/Bar Assessment was to ensure if bed rails (enablers) were safe for the resident or not. The DON stated the risk could be harm and the patient getting their limbs stuck on the bed. The DON stated the nursing staff were responsible for ensuring a Bed/Transfer/Bar Assessment was completed.</p> <p>During an interview on 01/22/25 at 11:05 AM, with the Administrator, she stated the purpose of a Bed/Transfer/Bar Evaluation was to see if the resident needed the bed rails (enablers) or not. The Administrator stated the negative outcome would be that the nursing staff would not be able to use it to see if the resident needed it or not.</p>		