

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/05/2026
Form Approved OMB
No. 0938-0391

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 11/25/2025
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for physician notification of changes. LVN A failed to immediately notify Resident #1's physician when Resident #1 showed a change in condition (blood in urine) on 08/01/2025. These failures could place residents at risk of a delay in treatment, decline in physical, mental, and/or psychosocial status. The findings included: Record review of Resident #1's admission record dated 11/24/2025 revealed an 89 y/o male, with an admission date of 06/17/2025 and a readmission date of 09/09/2025. Record review of Resident #1's History and Physical dated 10/08/25 revealed diagnoses of urinary retention, and benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland). Record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had a BIMS of 12 indicating moderate cognitive impairment. Record review of Resident #1's care plan revised on 10/27/2025 revealed Resident #1 had a catheter related to Benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland)/Urine retention. Interventions included monitoring urine, color, and amount as needed. Record review of Resident #1's progress notes section in the facility's PCC system reflected an entry dated 08/01/25 at 5:17 a. m. by LVN A that stated CNA reported to this nurse patient output only 25mls for the shift. This nurse noted red tinged urine in drain bag. This nurse attempted to adjust indwelling catheter and patient refused, stated he is doing ok. Will notify oncoming shift. Record review of Resident #1's progress notes section in the facility's PCC system reflected an entry dated 08/01/2025 at 4:03 p.m. by LVN B that stated Family member expressed concern that patient had very little drainage in foley bag with clots in tubing. Changed foley catheter, had light blood-tinged urine draining, then drainage became dark red. Notified MD/NP, ordered US of bladder, noted. In an interview on 11/25/2025 at 10:21 a.m., RN C revealed that changes of condition included any changes in residents vital signs, falls and injuries. She stated that Resident #1 had a foley catheter, and that CNAs was responsible for monitoring output. She stated that if the CNAs was to notice any change in the urine such as blood, they was to notify the nurse. The nurse would then assess the resident, notate the color, amount of urine. The nurse should then notify the physician right away and the oncoming nurse. The risk of not notifying the physician in a timely manner was that it created a delay in care for the resident. She stated that the nurse is responsible to ensure that the physician is notified of any changes in condition for all residents under their care during their shift. In a telephone interview on 11/25/2025 at 12:02 p.m., LVN B revealed that she did not recall the incident on 08/01/25, but she remembered that Resident #1 would frequently pull at his foley catheter. She stated that red tinged urine was something that should be reported to the physician because it could be considered a change in condition. She stated that the nurse was responsible for ensuring changes in condition was reported promptly to the physician for resident safety and well-being. In a telephone interview on 11/25/2025 at 12:40 p.m., the DON revealed that Resident #1 had a foley catheter bag draining to gravity. She stated that reporting a change of condition depends on what the change of condition was, such as a change in the level of consciousness, and vital signs. She stated that blood in urine should have been reported to the physician by the night nurse that first noticed it and then followed up on it by the day shift nurse. She stated that it was important for a change of condition to be reported to the physician in a prompt manner because if it was not then it could affect the resident's health overall, and it was also important to know that interventions apply. She stated that it was the responsibility of the nurses to ensure that they report the change of condition to physician, oncoming shift and to charge nurse and to DON. She stated that she could not recall if the night nurse called the physician to report noted blood in urine. She stated that she had conducted an in-service for reporting change in conditions to the physician, but she could not recall when. In an interview on 11/25/2025 at 1:20 p.m., the Administrator revealed that Resident #1 did not like the foley catheter and would frequently pull at it. He stated that he was not aware of the incident on 08/01/25 of blood in urine. He stated that the expectations for the nurses were to notify the physician promptly of any changes of condition and for the nurses to follow the doctors' instructions and document everything done. He stated that the risk of not notifying the doctor promptly was a potential for a decline in residents medical condition. He stated that it was the responsibility of the floor nurses to ensure that they were reporting anything out of the ordinary to the doctor. He stated that the last in-service done on reporting changes of condition was on 08/20/25. Record Review of change of condition in-service revealed		