STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745005	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Zaragoza, LLC	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that licensed nurses have specific competencies, and skill sets necessary to care for residents' needs, as identified through resident assessment for 1 of 6 residents (Resident #1) reviewed for nursing services.-The facility failed to ensure on 03/06/2026 that LVN A did not practice outside her scope of practice when she removed a PICC Line for Resident #1 when this needed to be completed by an RN, per Texas Board of Nursing standards. This failure placed the resident at risk for potential harm by nursing staff providing care outside of their scope of practice.The findings include:Record review of Resident #1's face sheet dated 3/20/2026 revealed a [AGE] year-old male with an original admission date on 4/28/2022 and a readmission date on 2/10/2026. Record review of Resident #1's MDS assessment dated [DATE] revealed the resident had a BIMS score of 11 with the significance being moderate cognitive impairment. Resident #1 was coded for diagnoses of atrial fibrillation (condition of rapid, irregular heartbeat), heart failure (a condition where the heart cannot pump enough blood to [NAME] the body's needs), pulmonary thrombo-embolism (life threatening blockage in a lung artery usually caused by blood clot), and had a pacemaker in pace.Record review of Resident #1's care plan dated 2/12/2026 revealed the resident had a focus of completing an antibiotic regimen via PICC line with a revision/completion date on 3/2/2026. Record review of Resident #1's physical and history dated 2/10/2026 revealed the resident had diagnosis of chronic systolic congestive heart failure (long term condition where the left ventricle weakens , reducing blood flow), chronic atrial fibrillation (a sustained heart arrhythmia where upper chambers quiver), ischemic cardiomyopathy with pacemaker (severe weakening of the heart muscle caused by plaque buildup or a heart attack), venous insufficiency (occurs when leg vein calves become weak or damaged and fail to return blood to the heart).Record review of the complaint allegation read in part, on 03/06/2026 [LVN A] removed the Peripherally Inserted Central Catheter (PICC LINE), from [Resident #1]. The complainant believes she is not supposed to remove the PICC Line without expressed permission or supervision from a Registered Nurse.Record review of Resident #1's progress notes dated 3/6/2026 at 6:19 PM completed by LVN A on Resident #1's profile read in part, patients midline discontinued per MD order using aseptic technique, measured at 10cm, tip intact and clean. Pressure applied 5 minutes, no active bleeding noted. Pressure dressing applied and patient made aware dressing can be removed in 3-4 hours. Tolerated procedure well. Patient resting comfortably in bed all safety measures in place, call light in reach.During an interview and observation on 3/20/2026 at 11:41 AM with Resident #1, he stated that he had been at the facility for a month. He stated he had a PICC line and it was removed while he was in the facility a couple weeks ago. He revealed a plastic cover inserted on his left tricep. He stated he did not remember who was in the room when the PICC line was removed. He stated he did not experience any pain or discomfort during the procedure. He stated he did not experience any pain discomfort or symptoms the days following. He denied feeling pain or discomfort on the extraction site during the interview. Observation of the PICC line extraction site showed no swelling, signs of infection, redness, or scabbing.During an interview on 3/20/2026 at 12:39 PM with LVN A, (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she stated she had worked at the center for a year and as an LVN for 16 years. She stated some of her responsibilities were to start intravenous lines, provide ADL care, provide wound care, complete admissions/discharges, and administer medication. She stated that PICC lines LVNs were only allowed to change the bandage dressing. She stated LVNs did not remove PICC lines. She stated it was not within their scope of practice to remove PICC lines. She stated that the RNs were responsible for pulling PICC lines. She stated that PICC line removal required an order from the provider. She stated the last in-service she received for clinical skills, was last year. She stated it affected residents if the LVN removed a PICC line, because there could be complications that were out of the LVNs' skills and scope of practice. In a follow-up interview at 2:29 PM, she stated she removed the PICC from Resident #1 and estimated it was a couple of weeks prior. She stated it was brought to her attention by the ADON and DON, and was notified that was not allowed by the Texas Board of Nursing regulations. She stated she was the only employee in the room and no other employee RN oversaw the process. She stated the resident was not affected by bruising, swelling, or discomfort/pain during the process. She stated there was no change in condition in Resident #1. She stated she had an informal conversation via text with the DON, and did not receive an in service/training for the incident. She stated the facility had not taken any action against her for removing the PICC line and added the nursing supervisors and administrator were aware for 2 weeks. She stated it affected residents if staff practiced out of their scope of practices drastically with problems of continuous bleeding, blood clots, hematomas.During an interview on 3/20/2026 at 1:05 PM, she stated, as an RN, she could perform TPN care, PEG tube, and assist with anything the LVNs and CNAs needed. She stated she did assist with PICC line care for antibiotics administration. She stated, per facility policy, only an RN can remove a PICC line with provider orders. She stated that the line was more invasive and ran from the arm veins to the general heart area. She stated it affected the residents because there could be significant pressure applied to the cite, ensure the site was fine, and the catheter was fine, and some bleeding would be present. She stated she had never removed PICC line in the facility. She stated it was out of the scope of practice for LVNs to be removing PICC lines. She stated the last in services for skills, competencies, and scope of practice was during orientation a year ago.During a phone interview on 3/20/2026 at 1:29 PM with the NP, he stated he provided orders to remove the PICC line, and would have expected an RN to complete the removal. He stated he would prefer an RN to complete the removal over an LVN. He stated there was no change of condition reported to him following the order for removal. He stated he was not aware of the scope of practice for an LVN, but was aware it was within the scope of practice for an RN to remove a PICC line. He stated that he had no concerns with the nurses at the facility and was made aware of all change in conditions promptly. During an interview on 3/20/2026 at 2:40 PM with the ADON, she stated that LVNs oversaw resident care and were supervised by RNs. She stated that an RN needed to be present with an LVN for removing a PICC line. She stated that LVNs were not allowed to remove a PICC line per the Texas Board of Nursing, the procedure needed further evaluation and monitoring by an RN due to the potential risks a resident could experience. She stated that there was a risk of the catheter breaking, infection, embolism (life threatening blockage of the blood vessel) and was considered care beyond the scope of practice for an LVN. She stated she was aware of an incident that LVN A removed the PICC line on Resident #1 under the discontinue orders for by the NP. She stated she was made aware of the incident on 3/9/2026 (next business day) during audits of progress notes. She stated she messaged LVN A and notified the DON immediately. She stated Resident #1 had already discontinued antibiotics that were administered via the PICC line. She stated she followed up with Resident #1, and he did not appear in distress, discomfort, affected by a change of condition, and did not voice any complaints/concerns about the procedure of removal. She stated she reported it to her DON, and added she had the power to enact a corrective measure before 3/20/2026. She stated it affected residents if LVN practiced outside of their scope of practice because there could be additional issues that an LVN might not possess the knowledge on how to handle a situation, and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what signs or symptoms to look out for. During an interview on 3/20/2026 at 3:04 PM with the DON, she stated she was made aware Resident #1 had his PICC line removed by LVN A on 3/9/26. She stated she notified LVN A about her scope of practice and referred her to the policies on the Texas Board of Nursing page on LVNs scope of practice for PICC lines. She stated that there was supposed to be a 1:1 in-service with the ADON and LVN A. She stated she appointed her ADON to complete the 1:1 the week of the March 9th. She stated she did not follow up to see if it was completed because she forgot due to obligations and working the floor. She stated she notified LVN A she could not be pulling PICC lines via text on 3/9 and in-person on 3/9. She stated she was not referred to the board of nursing or suspended. She stated there were no concerns, symptoms, or reports from Resident #1 regarding the procedure. She stated it could cause harm to the residents if LVNs were completing tasks outside of their scope of practice. She stated there was potential harm for not checking to see if the catheter was intact post-removal. She stated the last in-service for nursing competency check without a return demonstration was in 2025.During an interview on 3/20/2026 at 4:11 PM with the Administrator, he stated that he was aware that LVN A removed the PICC line from Resident #1 about a couple weeks ago. He stated his DON notified him. He stated that LVN A received in-servicing and education, but he was uncertain if it was 1:1 or facility-wide. He stated only RNs could remove the PICC line due to training and certification, and per the Texas Board of Nursing. He stated the resident was not affected, but there was the potential for harming the resident if LVN A was unaware what they were doing. He stated that Resident #1 did not complain about injuries or present a change in condition.Record review of the facility's 1:1 Education/In-service dated 3/13/2026 was addressed to LVN A by the Nursing Department and read in part, To clarify the Texas Boars of Nursing (BON) scope of practice regarding PICC lines removal and ensure safe, compliance care in the SNF setting.LVNs SHOULD NOT: Independently remove PICC lines, Make decision regarding central line removal, perform procedure without RN/provider oversight.Risks requiring RN-Level Care: Air embolism, catheter breakage, bleeding complications, infection risk. Acknowledgement: I understand that PICC line removal is outside my independent LVN scope in Texas and requires RN involvement. The 1:1 document was signed by LVN A on 3/20/2026 and explained by the ADON.Record review completed on 3/20/2026 of the webpage titled Practice - Texas Board of Nursing Position Statements under section 15.3 titled LVNs Engaging in IV Therapy, Venipuncture, or PICC lines read in part, .The Board has further determined that vocational nursing programs do not provide the LVN with the educational foundation to assure client safety in insertion and removal of Peripherally Inserted Central Catheters (PICC lines) or midline catheters, inclusive of vein selection, insertion/advancement/retraction of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion and removal.It is the Board's position that insertion and removal of PICC lines or midlines catheters is beyond the scope of practice for LVNs.