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	06/02/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right and the facility made prompt efforts to resolve resident grievances the resident may have for 1 of 4 residents (Resident #1) reviewed for grievances . The facility failed to follow their policy and procedure on Grievance/Complaints when Resident #1's family member voiced a concern on 02/19/26 to Human Resources regarding a concern about the oxygen tank not working when the resident was sent to a physician's appointments on 02/19/26 and concerned that the resident was not provided catheter care. This failure could place residents at risk of feeling their voices were not being heard or taken seriously and could cause feelings of worthlessness. Findings include:Record review of the Grievance Concern Report, dated 02/19/26, for Resident #1 revealed Patient representative had reported concerns to HR Manager T. Describe concern using factual terms: Family wanted to ensure Oxygen was full and foley had been cleaned. Family agreed to meet with IDT on 2/23/26 at 12:00 p.m. Documentation of facility follow-up: Family agreed to meet on 2/23/26 with HR, DON, Administrator, NP to review any/other concerns. Date assigned: Was left blank. Date to be resolved by: Was left blank. Was a group meeting held? Was left blank. What other action was taken to resolve concerns? (Specifics) Was left blank. Results of action taken: Was left blank. Plan care updated? Was left blank. Resolution of Concern: Was left blank. Executive Director's Signature: Was left blank. Typed statement attached to the Grievance Form was signed by the facility's Executive Director, dated 02/23/26, revealed, Meeting with Resident #1's family members. They wanted a follow up on oxygen portable tank and ensure it was properly working because they were informed at the appointment they were not sure the portable tank had air. They were informed tanks did not give the actual measure but staff were fully aware to pull the lower level to double-check it was full. They were informed all portable tanks were checked until 2/19/26 to include the tank was returned the same day. The family was grateful about the facility following to ensure all portable tanks were functioning properly in order to avoid or prevent any confusion in the future. They also needed to know about the foley being dirty and he was more ill, in the hospital and needed to know if it was because of the dirty foley. The Family was informed patient was in the facility for only 6 days and he was moved to the first hall at their request; family felt because the resident was confused and thinking he was still with the hospital and wanting to return to the facility. The Administrator had visited him that day and he was extremely confused and refusing care, wound care, ADL's, etc . When moved, he remained confused, but more at ease. They were informed Resident #1 came in from the hospital with 18 wounds and the NP stated he had lot of weight, very debilitated, refusing care and I even wanted him to be a DNR but left to the hospital. He also stated his lab work returned normal and no markers were identified. Family member said he was declining in the hospital and remembered he was the little troublemaker before he left to the hospital. Family asked for a smoking patch but resident was always anxious about smoking and always asking if he could go out and smoke. Family also stated Resident #1 felt he was at home and the nursing facility was his second home. They agreed with the meeting and said they would want him to return but had questions about his well-being; they also understood he (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned to the facility confused and refused wound care, which was already a concern from his first admission. In conclusion to the meeting, the family was aware transporters had been trained in detail to ensure all areas of transportation. The nurses were aware to check the resident with transporters before they left. The foley catheter was clean when resident left and was bagged properly. Family agreed to notify the center of any updates. Document was signed by the facility's Executive Director .Record review of Resident #1's History & Physical, dated 3/30/26, revealed a [AGE] year old male. Resident #1 had diagnoses which included dry gangrene (right posterior calf right heel (the death of body tissue caused by a sudden or gradual loss of blood flow, left foot left posterior calf) wound VAC (is a device that uses gentle suction to help large or slow-healing wounds close faster) to RLE, dry gangrene to the RLE posterior calf heel and digits bilaterally, LLE (left lower extremity) dry gangrene to the left foot and ankle extending posterior laterally to the mid-calf, pulses not palpable, peripheral artery disease, history of CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), gastrostomy tube (a soft flexible tube placed through a small opening in the stomach directly into the stomach) dependent 3/04/26, foley Catheter in place, right tibial osteomyelitis (a painful bone infection caused by bacteria or fungi), aspiration pneumonia (a serious lung infection caused by breathing food. Liquid, saliva, or vomit down the windpipe instead of the food pipe), chronic kidney disease on HD (a long-term condition where kidneys gradually lose function, facility to filter waste from blood, often progressing slowly with few initial symptoms leading to end-stage renal failure requiring hemodialysis), tinea Cruris with fungal cellulitis of the groin (deep skin infection caused by fungi rather than usual bacteria) and perineal area, and acute respiratory failure (a sudden, life-threating condition where the lungs cannot properly exchange oxygen and carbon dioxide). Alert, oriented x 3. Code Status: Full Code. Record review of Resident #1's MDS , dated 04/15/26, revealed, Type of Record: Modify existing record. PPS 5-day Assessment. Entry Date: 04/14/26. Reentry from acute hospital. Active Diagnoses: PVD (circulation problem where narrowed or blocked blood vessels outside your heart and brain reduce blood flow to your limbs and organs due to plaque buildup), Renal Failure, Pneumonia , Wound Infection, COPD (progressive lung disease that makes breathing difficult due to damaged airways and air sacs, causing inflammation, extra mucus, and air flow obstruction), Respiratory Failure, Gangrene, Gastrostomy, Feeding tube, Skin Tears, and continuous oxygen therapy. Record review of Resident #1's Care Plan, dated 04/14/26, revealed:-Patient has catheter. Interventions: Change foley catheter as ordered. Indwelling catheter care as ordered and as needed. Monitor urine odor, color, clarity and amount as needed.-I am at risk related to respiratory conditions and/or deficiencies/abnormalities in pulmonary function. Interventions: Administer oxygen as ordered. Keep HOB elevated. Monitor breath sounds as needed. Monitor for shortness of breath. -Full Code. Interventions: Staff will follow through with my wishes and implement resuscitation, when I am in need of drastic measures to facilitate breathing. Record review of Resident #1's admission Record, dated 5/29/26 , revealed an original admission date of 10/22/25 and re-admission date of 4/14/2026. The Resident expired at the facility on 04/15/26.During an interview on 05/29/26 at 10:42 a.m. with the Executive Director, he denied receiving a text message from the resident's family member requesting a meeting to discuss some concerns related to the care and services provided at the facility. He said the DON was the one who received the text message from the family member. He said the DON sent him a copy of the text message and would provide a copy of the screen shot as requested. He said he called the family member to follow up on her new concerns, and the family member refused to talk to him and asked him to speak to Human Resources T and never said why they wanted to speak to HR. He said, I am responsible for addressing Grievances and completing the Grievance Forms. He said he had not documented in the resident's medical record when he called the family member to schedule a meeting at the family's request. He said he could not remember why they had not held the meeting with the family member as requested. He said they had not completed a Grievance Form when the family member called to report she had concerns about the care and services that were provided to Resident (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 at the facility. He said, I know that we should have completed a Grievance Form according to our facility policy. During an interview on 05/29/26 at 11:28 a.m. with RN ADON, she said she was not aware if the family voiced any concerns about the care that was provided to the resident.During a telephone interview on 05/29/26 at 12:21 p.m. family member said they wanted justice for the resident . It was reported Resident #1 was discharged from the hospital with a diagnosis of sepsis (lifeˆthreatening reaction your body has when it overreacts to an infection) related to wounds . It was reported the resident arrived at the facility on 04/14/26 and expired on 04/15/26 at the nursing facility. The family member said the night nurse had not checked resident. The family member said when CPR was done at the nursing home, the nurse suctioned 100 ml of fluid. The family member said they asked the DON to please go to assess the resident at the hospital prior to him being sent to the facility. She said the DON told them the resident looked great and the resident spoke to her. The family member reported the resident's family member was very concerned because the resident could not talk when he was sent to the nursing facility from the hospital. The family member said she sent a text message to the Administrator asking him to call her to talk about the concerns she had about the resident, and he never responded. The family member said she deleted the text message that was sent to the Administrator from her cell phone. The family member said the DON promised her the Administrator and HR would meet with her, but they never called back to talk about the concerns she had about the resident. She said the DON told her the resident would be placed in a room by the nurses station so they could check on him. The family member said on the day the resident expired, the nurse who was assigned to him was on lunch break. The family member said the resident had not been checked as DON had said they would. The family member also reported the resident was sent to an appointment, and she was informed by the physician's office staff the oxygen tank was not working, and the resident was not getting his oxygen as ordered. The family member said the doctor's office staff called 911 and the resident was sent to the hospital. The family member reported when the resident arrived at the hospital the resident's penis was full of crusted drainage. The family member said she called the facility to report her concern to the Administrator and Human Resources, and they scheduled a meeting on 04/29/26. The family member said when she went to the nursing facility on 04/29/26 at 12 noon, for the scheduled meeting with the DON, the Administrator and Human Resources she was informed the meeting could not be done as scheduled because the Administrator was not at the facility. The family member said the Administrator never called back to reschedule the meeting. During an interview on 05/29/26 at 4:00 p.m., with the Executive Director and Human Resources T revealed a family member called the facility on 02/19/26 to request a meeting with the Executive Director and HR to discuss some concerns about the care that was being provided for the Resident #1. The Executive Director said he, the DON and HR met with the family member on 02/23/26 to discuss concerns about the oxygen tank not having oxygen when Resident #1 was sent to an appointment and could not remember the date and the family had also reported the foley had not been cleaned on that da y. He said the resident was sent to the hospital from the doctor's office on that day and did not know why. He said he informed the family member all the facility's portable oxygen tanks were checked on 02/19/26 by the Maintenance Director, that included the portable oxygen tank Resident #1 took to his doctor's appointment on that day and no issues were identified. He said he did not know if the Maintenance Director had any documentation of when he checked the portable oxygen tanks on that day . He said the family was grateful for the facility following up to ensure all portable oxygen tanks were functioning properly. He said the family member had also reported the resident's catheter was dirty when he had arrived at the hospital and needed to know if that was what had caused the resident to get sick and had been the reason for hospitalization. He said, I think nursing had checked the catheter and there were no concerns. He said the facility's transporters were trained in detail to ensure all areas of transportation were covered and were instructed to have the nurse check the resident before they left the facility. He said the nurse reported the resident's catheter was clean when the resident left the facility to go to the physician's (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	office on 02/19/26. He said they had not documented in the resident's clinical record they had met with the family on 02/23/26. He said the portable oxygen tank did not give the actual oxygen contents. He said the portable oxygen tanks only had a gauge that showed green if the tank had oxygen or red if the tank was empty. He said the resident was moved to the first floor at the family's request and could not remember why the family had requested the move. He said the resident was confused. He said the resident was readmitted from the hospital with eighteen wounds and he suggested to the family to make the resident a DNR. He said he could not recall when they scheduled the second meeting with the resident's family and could not remember why the meeting was not held as scheduled . During an interview on 06/01/26 at 10:30 a.m., Maintenance Director B said he checked all the portable liquid oxygen tanks on 02/19/26 when he was informed Resident #1's family member reported the resident was sent to an appointment and the portable oxygen tank was not working. He said he had not found any portable oxygen tanks that were not working properly. He said he did not have any documentation that he had checked the portable oxygen tanks on 02/19/26 . During an interview on 06/01/26 at 11:49 a.m. with the DON, she said she was aware the family had some concerns but could not remember what they were. She said, The only time I became aware of any family concerns was when we met the family on 02/19/26 and the Administrator completed the Grievance Form. During an interview on 06/02/26 at 9:58 a.m., Human Resources T said she remembered when a family member called on 02/19/26 asking to have a meeting with her, the Administrator and the DON and had voiced two concerns related to sending the resident to an appointment with an empty oxygen tank and a concern about the resident's catheter. She said, I wrote down her concerns and gave the piece of paper to the Executive Director. I do not remember that date that I handed the note to the Executive Director . She said she did not know why the resident's family member wanted her to be present at the meeting because she was only involved with issues that were related to the staff. She said she was not aware the family member had called again to request another meeting to discuss concerns about the care provided to the resident .During a telephone interview on 06/02/26 at 11:05 a.m. with CNA Q she had not been provided with any training at the facility on how to check the portable liquid oxygen tanks. She said, she learned how to read the gauge on the portable liquid oxygen tanks at her previous employment. She said, You hold the shoulder strap closest to the gauge on the tank and slightly tilt it downward to see if the gauge moves to the green area which indicated there was oxygen in the portable oxygen tank. She said she was trained on how to give catheter care to a male resident approximately 6-9 months ago. She said she occasionally found residents with crusted drainage on the penis. She said she had not reported this to the nurse, due to fear of retaliation . Record review of the facility's Grievance Policy and Procedure, revised 02/08/2021, provided by the Executive Director on 06/01/26 at 6:20 p.m. revealed: Purpose: To ensure all patients, legal representatives/responsible parties, staff and visitors are aware of the facility's grievance procedure. Policy: Each patient's legal representative and his/her responsible parties, family members, staff, and visitors have the right to voice complaints and/or grievances without discrimination or fear of reprisal. Such grievances include those with respect to care, treatment, or other matters relating to quality of care or quality of life. Grievances can be communicated to a staff member either verbally or in writing. The facility will make every effort to promptly investigate and resolve any grievances . Responsible Areas: All Staff. Procedure: All grievance should be given to the Executive Director or Designee. All patients, legal representatives and/or responsible parties are provided with information concerning his/her right to voice grievance either in writing or verbally. All patients will be informed of the location of the facilities grievance forms should they wish to write a formal complaint. Any patient who wishes to do so may express his/her grievances in writing or verbally to any staff member; However, they are strongly encouraged to express the complaint(s) directly to the Social Services, Executive Director or the Manager on Duty. If the complaint is verbal, it is the responsibility of the staff member who received the complaint to properly complete the grievance form on behalf of the complainant. The complaint form must be (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to the Executive Director or Designee immediately. The agreements will be given to the appropriate department manager for follow up and resolution. All grievances will be reviewed in morning meeting with IDT members. Department managers are responsible for resolution of all complaints within his/her department. Department managers will note the disposition of the grievance in writing to the Executive Director or Designee as soon as possible, but no later than 72 hours of receipt. It is responsibility of the Department Manager in coordination with the Executive Director, when appropriate, to develop a process/plan for resolution of the grievance and notify the complainant about the plan of resolution. All actions taken on the grievance including meetings with the patient, telephone calls, action plans, revision of care plan, etc. must be documented on the grievance form. If the complainant or aggrieved part is dissatisfied with the findings and/or remedies, the Executive Director will make reasonable attempts to resolve the grievance. The Ombudsman will be notified if the grievance is not resolved, per patient/family representatives request .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 4 residents (Resident #3) reviewed and 1 of 1 oxygen storage room reviewed for respiratory care. 1. The facility failed to check Resident #3's portable oxygen tank to ensure the oxygen tank was full when preparations were made to discharge the resident home on [DATE] to administered oxygen continuous at 2 L/min via nasal cannula. 2. The facility failed to ensure 21 oxygen metal cylinders, stored in the main oxygen storage room, were properly stored.These deficient practices could place residents at an increased risk of developing respiratory complications, a decreased quality of care not receiving oxygen support due to improper storage .The findings include: Record review of Resident #3's History & Physical, dated 5/04/26, revealed a [AGE] year-old male with a complex medical history of CHF (heart muscle becomes weakened or stiff and cannot pump blood efficiently to meet the body's needs), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) , dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities such as memory, thinking, language, problem-solving, judgement, and orientation), Pacemaker dependency (your heart's natural rhythm is so weak or absent that it can't keep your heart beating at a safe rate without the help of a pacemaker), Cirrhosis (permanent scarring of the liver), ESRD (end stage renal failure, last stage of kidney disease) on dialysis and Asbestosis (lung disease caused by breathing in asbestos fibers over a long period of time). Presented on 04/23/26 following a fall resulting in an acute right intertrochanteric femur fracture. Right hip surgical incision. admitted for Orthopedic/Rehab. Record review of Resident #3's admission MDS, dated [DATE], revealed, Entry date 05/04/26, admitted from acute hospital. Clear speech, makes self-understood, and understood others. Resident #3 had a BIMS Summary Score 9 (cognitively moderately impaired). Resident #3 used a Manual wheelchair and was Incontinent of Bowel & Bladder. Resident #3 had Active Diagnoses which included: CHF, hypertension (high blood pressure), cirrhosis (permanent scarring of the liver), ESRD (end stage renal failure, last stage of kidney disease), dementia (loss of thinking, memory, and reasoning abilities that interfere with daily life), sleep apnea (condition where your breathing repeatedly stops or becomes very shallow while you sleep, causing poor sleep quality and potential health risks). Recent surgery. Hip fracture and surgical wound. High-Risk Drug Classes: Antipsychotic, Anticoagulant, Antibiotic, and Opioid. Resident #3 received Oxygen therapy-while a resident. The resident's Overall Goal: Discharge to the community. Discharge Plan. discharge date 3 or fewer months away. Record review of Resident #3's Care Plan, initiated 05/04/26, revealed: -I am at respiratory risk related to my respiratory condition and/or my abnormalities in pulmonary function. Interventions: Administer oxygen as ordered. Monitor breath sounds as needed. Monitor for shortness of breath with exertion, edema (swelling caused by excess fluid building up in the tissues of your body) to extremities and c/o of dizziness and fatigue. -I want to establish goals for myself and to be involved in my discharge planning process. Interventions: Contact appropriate community agencies as needed when patient was ready for discharge. Record review of Resident #3's Physician's Order Summary, dated 06/02/26, revealed, Order Date: 06/01/26 Oxygen concentrator with portable device. Oxygen Order: 2 L/min continuously via nasal cannula. Length of time needed: Lifetime. Diagnosis: Respiratory Failure with hypoxia (your body or parts of it aren't getting enough oxygen), related to aspiration pneumonia (a lung infection that happens when food, drink, saliva, or stomach contents accidentally get into your lungs instead of your stomach). Record review of Resident #3's IDT notes, dated 05/03/26 to 06/03/2026, revealed:-Daily Nursing Note, dated 06/01/26 at 8:21 a.m., written by the DON revealed: Patient was evaluated for trial weaning from supplemental oxygen per current care plan and respiratory status assessment. Oxygen was gradually reduced while monitoring patient (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tolerance and oxygen saturation levels. During the attempt to wean, patient's oxygen saturation decreased below baseline parameters. Patient was observed to desaturate to 87% on room air. Patient remained alert but unable to maintain adequate oxygenation without supplemental oxygen. -Care Plan Note, dated 06/01/26, written by LVN Case Manager O, revealed Patient. will be discharged today with to[city, state] . Home H ealth referral sent and DME referral sent to provider. -Discharge Note, dated 06/01/26 at 11:51 a.m., written by LVN C, admission Coordinator revealed Education provided to prior to discharge on all medication administration and oxygen use. Patient discharged from facility at 11:51 a.m. Patient was discharged with private vehicle going back home to [city, state]. All medications and personal belongings sent with the patient and . 1. Record review of Resident #3's admission Record, dated 6/02/26 , revealed an admission date of 5/04/2026.Observation on 06/01/26 at 11:26 a.m. accompanied by the DON and admission Coordinator LVN C revealed Resident #3 was sitting in a wheelchair and the family member was pushing the wheelchair by the nurses station. It was observed the resident had a portable liquid oxygen tank hanging from the strap on the back of his wheelchair and a nasal cannula in place. admission Coordinator LVN C and the DON were talking to Resident #3 and . admission Coordinator LVN C said the resident was getting ready to be discharged home and was driving him back home . The admission Coordinator LVN C was asked to check the oxygen level in the portable liquid oxygen tank. LVN C said, This is how we check the level of liquid oxygen, by holding the tank by the straps and slightly tilt it to one side. She kept moving the tank from side to side and she said the contents indicator was not moving. It was observed the carrying strap had a plastic buckle located in the middle of the carrying strap that was not disengaged to check the liquid oxygen contents. She moved her hand on the strap nearest to the contents indicator and it was observed the contents indicator revealed the oxygen tank was empty. admission Coordinator LVN C said she was filling in for the RN X who was assigned to Resident #3 . She said she had taken over RN X's assignment at 10:00 a.m. and the resident's was already at the facility to take the resident home. She said she did not know if RN X filled the portable oxygen tank before she left. admission Coordinator LVN C said she had not checked the contents in the portable tank prior to the family member taking the resident out of the room to wheel the resident to their private vehicle to drive him back home. It was observed admission Coordinator LVN C immediately went to fill the portable liquid oxygen tank in the oxygen room located directly in front of the nurses station. The DON said the nurses were responsible for checking the portable oxygen tanks were full prior to discharging a resident and/or when residents went out to appointments. She said the risk of not checking the portable oxygen tank contents could result in the resident not receiving the prescribed oxygen and potential medical complications. During an observation and interview on 06/01/26 at 11:42 a.m., the resident's family member said she was not aware if the nurses checked Resident #3's portable oxygen tank prior to her wheeling the resident out of the room to take him to her truck to drive him back home . The family member said the resident was on continuous oxygen and it was a four-hour drive to get back home . She said the facility let her borrow one of their portable liquid oxygen tanks to take the resident back home. She said she had not checked the contents of the oxygen tank because she assumed the nurses had filled the oxygen tank prior to her taking him out of the facility to put him in her truck. During an interview and record review on 06/02/26 at 10:39 a.m. with the DON revealed Resident #3 had a physician's order to administer oxygen at 2 L/min when he was discharged home on [DATE] .During an interview on 06/02/26 at 10:45 a.m., LVN Case Manager O said she could not remember how many liters of oxygen were ordered for Resident #3 on the day of discharge, on 06/01/26. She said oxygen would need to be administered according to physician's orders and the nurse who was assigned to the resident at the time of discharge was responsible for checking the oxygen tank was full prior to discharging the resident. 2. During an observation and interview on 06/01/26 at 11:19 a.m. with Maintenance Supervisor B in the presence of the Executive Director revealed, there was a locked oxygen storage room that had a keypad lock. There were twenty-one H metal oxygen cylinders stored on the concrete floor and the oxygen cylinders were not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physically chained to the wall or placed in a rack to prevent tipping in the same room where there were multiple large tanks of liquid oxygen stored. It was observed that nine of the H metal oxygen cylinders were stored on the floor, close to the entrance door to the oxygen room that was not secured or physically chained to the wall. The chain was on the cement floor on the opposite side of the room directly across from where the other 12 oxygen metal cylinders were. Maintenance Director B said, Those are not H tanks, they are K tanks and weigh 400 lbs . and do not need to be secured with a chain because it would be very difficult for tipping them over. There were three H metal oxygen cylinders that did not have the metal cylinder cap to cover the valve when the oxygen tank was not in use. A copy of the Oxygen policy related to the use of metal oxygen cylinders was not provided prior to exit . Record review of the facility's Liquid Oxygen Storage & Transfer Policy and Procedure, revised 02/08/21, provided by Maintenance Supervisor B revealed: Purpose - The Center aim to keep patients, guess and employee safe from hazardous exposure to liquid oxygen. Policy: The Center will follow the NFPA 99 standards for the safe storage, transfer and use of liquid oxygen. Procedure: Storage room must be kept locked against unauthorized entry. Floors must be ceramic or concrete.

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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Zaragoza, LLC	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)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #2) reviewed for quality of care .The facility failed to ensure RN D wrote the verbal order given by the Nurse Practitioner on 05/08/26 for Resident #2 for a UA with Culture & Sensitivity. This failure could place residents at risk of delayed treatment/intervention and decline in health. Findings include:Record review of Resident #2's admission MDS, dated [DATE], revealed a BIMS Score 10 (cognitively impaired), occasionally incontinent of urine. Active Diagnoses: ESRD, and UTI in the last 30 days.Record review of Resident #2's Care Plan, dated 05/03/26, revealed the resident had incontinence of bowel & bladder. Record review of Resident #2's Daily Skilled Nurses Note, written by RN D at 3:06 p.m ., NP N in facility, new order for UA with C&S to be done.Record review of Resident #2's Daily Nursing Note, dated 05/11/26 at 9:45 a.m., written by LVN E, revealed NP N in facility rounding this AM at 8:00 a.m. NP N inquired about UA that was ordered on Friday 05/08/26 with RN D. This nurse was unable to find order for UA and no results were displayed. NP N made aware of findings, per NP N order UA with C&S today. Order placed pending UA collection. Record review of Resident #2's Daily Nursing Note, dated 05/11/26 at 2:53 p.m., written by LVN E, revealed Urine specimen collected via clean catch, sample placed if fridge pending lab pick up .Record review of Resident #2's History & Physical, dated 5/19/26, revealed an [AGE] year-old female who was re-admitted following an acute hospitalization for an acute exacerbation of chronic obstructive pulmonary disease and asthma, complicated by acute hypoxic respiratory failure, community acquired pneumonia, advanced dementia with agitation, and progression to end-stage renal disease. Record review of Resident #2's admission Record, dated 5/29/26 , revealed the original admission date was 12/24/25 and re-admission date was 05/19/2026. During an interview and record review on 05/29/26 at 4:19 a.m., RN ADON A said RN D had not written the Verbal Order on 05/08/26 that was given by NP N for a UA with C&S. She said according to the IDT note written on 05/11/26 by LVN E, revealed NP N was in the facility making rounds on 05/11/26 at 8:00 a.m. and inquired about the UA results that were ordered on 05/08/26. The NP stated he gave RN D a Verbal order for a UA with C&S on Friday 05/08/26 and RN D failed to enter the order in the resident's clinical record. ADON A denied knowing the order for the UA given on 05/08/26 was not carried out .During an interview on 06/01/26 at 12:40 p.m. with the DON revealed she had not been informed by LVN E on 05/11/26 that the UA with C&S had not been done on Resident #2 as ordered by NP N on 05/08/26 by RN D. She said the nurses were trained to immediately report to her or the ADON if labs were not done as ordered. She said the facility did not have a tracking system in place to track when labs were ordered and done according to physician's orders . She said the nurses entered the new lab order into the electronic records that alerted the Lab there were new orders pending to be completed. The DON said the NP would give verbal orders and the nurse was responsible for entering the verbal orders in the resident's electronic record to ensure physician's orders were carried out. She said the failure to write the verbal order for the UA for C&S on 05/08/26 placed the resident at risk of not receiving the necessary medical care to meet her needs . During an interview and record review on 06/01/26 at 1:05 p.m. with RN D, revealed she was given a verbal order from NP N for a UA with C&S on 05/08/26 for Resident #2 and had not entered the new order in the resident's electronic clinical record . She said she had not collected the urine because the resident said she did not feel she could urinate at the time she went to collect the urine sample. She said she offered the resident a straight catheterization (in -and-out catheterization to drain urine from the bladder) and the resident refused. She said she was going to try and collect the specimen the next day. She said she notified the on-coming nurse, LVN Y, that she had not been able to collect the urine sample but had not documented this in the resident's clinical (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record . She said, I think that I wrote this in the 24-Hour Report , but I am not sure. She said she had not notified the NP about not being able to collect the urine as ordered but had not documented the notification in the resident's electronic record. She said she was trained in nursing school to notify the physician or NP if unable to collect the urine sample as ordered. She said she was also trained to report to the DON and/or ADON if unable to collect urine for UA for C&S as ordered. She said she was not aware of the facility's policy on notifying the physician and/or NP if labs were not done as ordered. She said she was not aware of the facility's policy and procedure on Laboratory Services. She said the failure to write the verbal order for the UA for C&S on 05/08/26 placed the resident at risk of not receiving the necessary medical care to meet her needs.During a telephone interview on 06/01/26 at 1:43 p.m. with LVN E revealed she worked on 05/11/26 and was assigned to Resident #2 when NP N was making rounds and asked for the UA with C&S results that he had ordered on 05/08/26. She said she noted RN D had not written the order in the resident's electronic record on 05/08/26 and the UA with C&S had not been done as ordered. She said the nurses were trained to immediately notify the physician and/or NP if the nurse was not able to collect the urine sample as ordered and to document the notification in the resident's electronic clinical record. She said they also were trained to report to the DON and/or ADON if the nurse could not collect the urine specimen according to physician's orders. Telephone interview on 06/02/26 at 10:12 a.m., NP N said he had given a verbal order on 05/08/26 to the RN D who was assigned to Resident #2 for a UA with C&S. He said he had come to see Resident #2 on 05/11/26 and had inquired about the UA results for the UA with C&S that had been given on 05/08/26 and was informed by LVN E who was assigned to Resident #2 on 05/11/26 that the lab order he had given on 05/08/26 for the UA C&S had not been written and had not been done as ordered. He said this placed the resident at risk of untreated UTI .Record review of the facility's policy and procedures on Laboratory Services, revised on April 2, 2024 , provided by the DON revealed: The facility shall provide or obtain laboratory services only when ordered by a physician; physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. File in the resident's clinical record signed and dated reports of ordered lab work.