STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745038	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Este Nursing and Rehabilitation Center	14300 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43871 Based on interview and record review, the facility failed to implement written policies that prohibit and prevent abuse for 1 of 9 employees (the Administrator) reviewed for criminal back ground checks. The facility failed to run the Administrator's criminal background check prior to her starting her duties on 12/04/23. This failure could place residents at risk of potential abuse. The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering: Findings included: Record review of the Administrators undated New User Access Approval revealed a start date of 12/04/23. During an observation and record review of the employee background checks on 06/27/24 at 9:44 am, HR stated the Administrator had started working for the company on 12/04/23 and the criminal background check was completed on 12/14/23 . HR stated all administrative positions' criminal background checks were completed by corporate. HR stated she had just received a call notifying her about the Administrator start date on 12/04/23. HR stated during one of her audits in December 2023 she had noticed the Administrator did not have a criminal background check copy on her file and ran one on 12/14/23. HR stated she did not ask the corporate about it and just completed it to have it on record. HR stated she had reached out to corporate to ask for proof that they had completed a criminal background check on the Administrator prior to her start date and had not yet received anything. HR stated by not completing criminal background checks on potential staff before their start date could place residents at risk of possible abuse and neglect. During an interview on 06/27/24 at 10:40 am, the Retail HR stated she was the one who ran the DON and the Administrator background checks. The Retail HR stated she ran the Administrator's background check on 12/01/23. The Retail HR stated the facility could not have people working on the floor if the background check had not been completed prior to them starting their shift. The Retail HR stated the criminal background checks were important to ensure the facility did not hire felons and/or non-rehire-able personnel. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/28/24 at 8:44 am, HR stated she was notified yesterday (06/27/24) that corporate did not have copy of the Administrators criminal background check that was allegedly ran on 12/01/23. Record review of Abuse, Neglect and Exploitation policy dated 03/04/24 read in part It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property .The components of the facility abuse prohibition plan are discussed herein: I. Screening- A. potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1- background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2- screenings may be conducted by the facility itself, third-party agency or academic institution. 3- the facility will maintain documentation of proof that the screening occurred.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to other officials (including State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law for 2 of 7 residents (Resident #1 and Resident #4) reviewed for abuse. The facility failed to report resident to resident altercation to HHSC involving Resident 31 and Resident #4. This failure could place residents at risk of continued abuse. Findings included: 1. Record review of Resident #1's face sheet dated 06/25/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #1's progress note dated 06/23/24 written by LVN A revealed Nurse responded to call from resident [Resident #1]. He claims his neighbor bumped him with his WC. When this nurse went to assess the situation, [Resident #4] stated that resident [Resident #1] hit him with a pole. Inspection of [Resident #4] was negative for bruising or redness. [Resident #4] stated that he was trying to pass by [Resident #1's] bed. He stated the pass way was blocked by [Resident #1] WC and accidently bumped the WC, The WC then bumped into [Resident #1] side. As a result. [Resident #1] struck [Resident #4] with a pole. Resident [Resident #4] denies and pain or discomfort. Nurse called ADON and informed her of situation. ADON advised to move [Resident #4] to room [ROOM NUMBER]B for safety precautions. Record review of Resident #1's progress note dated 06/24/24 written by DON revealed Spoke to resident (Resident #1) regarding last night incident with roommate. resident state he only tapped resident with cane to get his attention since roommate was moving his wheelchair. Educated resident on not using cane or any other equipment to get any residents attention. Canes removed from room for safety. resident in understanding. Emergence Caseworker will be in to speak to resident as well. Record review of Resident #1's progress note dated 06/24/24 revealed resident [Resident #1]picked up at 1640 (4:40 pm) for transport to local behavior unit. Complaint with transfer onto stretcher and all paperwork sent with EMT's. Signed consent with paper work. 2. Record review of Resident #4's face sheet dated 06/25/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #4's BIMS assessment dated [DATE] revealed a BIMS score of 1, indicating his cognition was severely impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's progress notes dated 06/23/24 revealed no assessment documented regarding the resident-to-resident altercation (Resident #1 and Resident #4). Record review of Resident #4's assessments dated June 2024 revealed no skin assessment completed on 06/23/24 for the resident-to-resident altercation. 3. Review of Tulip on 06/25/24 at 11:06 am, revealed no self-repot from the facility found regarding resident-to-resident altercation involving Resident #1 and Resident #4. During an interview on 06/25/24 at 9:39 am, Resident #4 was alert and oriented to person only. Resident #4 denied any concerns with roommate and denied any resident-to-resident altercation. Resident #4 did not show signs of distress. Resident #4 stated he felt safe in the facility. During an interview on 6/25/24 at 10:05 am, a call was placed to Resident #1's listed number. There was no answer and left VM to return the call. The call was not returned before date and time of exit on 6/28/24. During an interview on 06/25/24 at 10:07 am, a call was placed to Resident #1 second listed phone number listed. The voice mail was not set up, and Surveyor was not able to leave voicemail. During an interview on 06/25/24 at 10:08 am, the Case Manager stated he was aware of the incident that occurred on 06/23/24. The Case Manager stated he had been notified by a nurse that Resident #1 had become upset and hit Resident #4 with a cane. The Case Manager stated he visited Resident #1 on Monday 06/24/24 and spoke to Resident #1 in which he denied hitting Resident #4 and stated he had only tapped Resident #4 with the cane. Case Manager stated he had asked Resident #1 for permission to review the camera footage . The Case Manager stated in the video footage, the Social Worker, DON, and himself were able to see that Resident #4 had passed by to get to the restroom and on his way back to his bed, Resident #1's wheelchair was in the way. Resident #4 was seen trying to move the wheelchair in attempts to get to his side of the room and Resident #1 became upset. Resident #1 then grabbed his cane and swung at Resident #4 because of the placement of the camera and the privacy curtains they were unable to determine if Resident #1 had hit Resident #4. The Case Manager stated Resident #1 was seen swinging and aimed the cane towards Resident #4 in attempts to hit him. The Case Manager stated Resident #1 had been transferred to local behavioral unit for further evaluation and hopefully medication adjustment. The Case Manager stated it was the first time he had known Resident #1 to have a physical aggression outburst. During an interview on 06/25/24 at 11:14 am, LVN E stated he had worked on 06/23/24 and was the nurse that responded to Resident #1 and Resident #4's altercation. LVN E stated he heard Resident #1 call out for him for assistance. LVN E stated when he arrived at Resident #1 room, Resident #1 told him Resident #4 had been bumping into his wheelchair and Resident #4 had stated he had been hit with a pole. LVN E stated Resident #4 stated he had been hit on his upper right extremity. LVN E stated he separated both residents to provide Resident #4 safety. LVN E stated he reported the incident to the ADON. During an interview on 06/25/24 at 11:32 am, a call was placed to Resident #4's RP. There was no answer, and a voicemail was left with information to return the call. The call was not returned by date and time of exit on 6/28/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/24 at 2:30 pm, the ADON stated she had been notified of Resident #1 and Resident #4 altercation by LVN E and gave instructions to remove Resident #4 from the room for safety. ADON stated she reported the incident to DON that same night (06/23/24). During an interview on 06/25/24 at 2:30 pm, the DON stated she had been notified of Resident #1 and Resident #4 altercation. The DON stated on 06/25/24 when she followed up with Resident #1, she noticed the cane was still in his room and kindly told Resident #1 she needed to remove it for safety concerns. The DON stated her, and the Administrator discovered the nature of the details of the incident in the morning when they were reviewing the 24-hour report. The DON stated she initiated the investigation and was not sure if the Administrator reported it to HHSC Agency. The DON stated the Administrator was the one responsible for reporting any abuse allegations to HHSC Agency. The DON stated she reported to Resident #4's RP and MD . The DON stated no new orders were provided for Resident #4 and Resident #1 had been transferred to local behavioral unit for further evaluation. During an interview on 06/25/24 at 3:12 pm, a call was placed to Resident #4's RP. There was no answer, and a voicemail was left with information to return the call. The call was not returned by date and time of exit on 6/28/24. During an interview on 06/26/24 at 8:41 am, the Administrator stated she had reported the incident to corporate and they stated that based on findings, they did not have sufficient evidence to show that Resident #1 had hit Resident #4 with a cane and therefore they decided it was not reportable to HHSC. Record review of Abuse, Neglect and Exploitation policy dated 03/04/24 read in part It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property.VII Reporting/ Response: A. The facility will have written procedures that include: 1. A- reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframes. Immediately, but no later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observations, interviews, and record reviews, the facility failed to provide the necessary treatment and services based on the comprehensive assessment and consistent with professional standards of practice for 1 (Resident #3) of 7 resident reviewed for quality of care. The facility failed to date/initial Resident #3's dressings after treatment was done. This deficient practice could place residents at risk for worsening venous injuries, pain, and a decline in health. The findings include: Record review of Resident #3's face sheet dated 06/27/24, revealed, admission on 01/25/24 and re-admission on 02/28/24 to the facility. Record review of Resident #3's facility history and physical dated 02/07/24, revealed, a [AGE] year-old male diagnosed with lymphedema, chronic venous hypertension, leg wound, and elephantiasis (It is caused by infection with parasites classified as nematodes (roundworms) that are transmitted through the bites of infected mosquitos). Record review of Resident #3's quarterly MDS dated [DATE], revealed, an independently intact cognition IBMS score of 15 to be able to recall and make daily decisions. Resident #3 was diagnosed with wound infection, lymphedema, elephantiasis, and cellulitis (a deep infection of the skin caused by bacteria). Resident #3 was marked for infection of the foot. Treatment was pressure ulcer/injury care, application of nonsurgical dressings, and ointments/medications. Record review of Resident #3's care plan dated 03/05/24, revealed, venous ulcers to his left posterior shin due to history of ulcers, vascular insufficiency. Lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), venous hypertension to lower extremity anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells). Observe/document/report as needed any signs of infection such as: drainage, odor, redness, swelling to the nurse. Wound/dressing: observe dressing. Change dressing and record observations. Record review of Resident #3's order recap dated 05/30/24, revealed, Wound care to left dorsal foot venous ulcer. Cleanse with normal saline, pat dry, apply Medi-honey and dry protective dressing one time a day every Tuesday, Thursday, and Saturday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/25/24 at 10:21 AM, revealed, Resident #3 was in his room standing up next to a tray table. Resident #3's left foot had a dressing that was not dated or initialed. A yellowish substance could be seen through the dressing. The edges of the dressing were peeling off exposing the gauze and wound. To the outer side of the left leg was another dressing with a yellowish substance. There was no date or initials. Right above the foot dressing was another dressing wrapping around the shin with no date/initials. Behind the left foot, the wrapped around dressing had no date/initials. Resident #3's right leg, behind the right leg was a dressing towards the bottom of the foot. Yellowish substance was towards the bottom of the dressing and on the edges of the dressing. Right above is a dressing wrapped around the leg with no date or initials. Right front and outside of the leg with the dressing did not show any date or initial. Observation on 06/27/24 at 2:14 PM, revealed, the left foot dressing was dated and initialed. The dressing had a bright yellow substance on it. The dressing above was not dated or initialed. During an interview on 06/25/24 at 10:19 AM, with Resident #3, he stated he had his wound dressing changed once a week by the nurses. Administration Report revealed Resident #3 was receiving his wound care as ordered 3 times a week. During an interview on 06/26/24 at 10:33 AM, with the DON, she stated the facility's Wound Care Nurse would conduct the wound care for the residents during the weekdays. The DON stated if the Wound Care Nurse was not there, then the floor nurses could change the dressings. The DON went through the steps of providing wound care and mentioned that once the dressing was wrapped it had to be dated and initialed by the nurse providing that care treatment. The DON stated you put the date the wound care was done and initial it by the whoever did the wound care. The DON stated it was standard procedures nurses should follow. The DON stated the risk would be infection. During an interview on 06/27/24 at 1:55 PM, with RN C, she stated if the Wound Care Nurse was not at the facility, the floor nurses were responsible for providing wound care. RN C stated she worked on 06/25/24 from 6AM-2PM. RN C stated she provided wound care for Resident #3 later in the day. RN C stated the edges of the dressing were coming undone and was not dated or initialed. RN C stated the nurses were trained on providing wound care for the residents. RN C stated she did not see the bandages earlier in the day and if she had, she would have provided wound care on Resident #3. RN C stated the risk of the edges coming off would be bacteria getting in. RN C stated the initialing would be for accountability and show when wound care was last provided. During an interview on 06/27/24 at 2:00 PM, with Resident #3, he stated RN C provided wound care on 06/25/24. During an interview on 06/27/24 at 2:05 PM, with the Wound Care Nurse, she stated the dressings had to be dated and initialed. The Wound Care Nurse stated the dressing having the edges coming off and having a yellowish substance would require them be changed. The Wound Care Nurse stated the risk would be infection or the wound worsening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/28/24 at 9:43 AM, with RN C, she stated the Wound Care Nurse was responsible for changing the dressings on residents with venous ulcers. RN C stated the floor nurses were to change the dressing if there was no Wound Care Nurse present in the facility. RN C stated Resident #3's tape around the dressing was peeling off and there was no initial of who had changed it. RN C stated the CNAs did not notify her of the way the dressing looked with the dressing peeling off and the dressing having a yellowish substance on it. RN C stated if she would have seen it, she would have either called the Wound Care Nurse to come and change it or she would have done it herself. RN C stated the risk would have been infection. Record review of the facility's wound Treatment Management policy dated 06/2022, revealed, Policy-To promote wound healing of various types of wounds, it was the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Dressing changes may be provided outside the frequency parameters in certain situations:

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 3 (Resident #5) residents reviewed for quality of care, in that: The facility failed to maintain communication, coordination, and collaboration with the dialysis facility for Resident #5. This failure could place residents who received dialysis treatments at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #5's face sheet dated 06/26/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #5's history and physical dated 11/10/23 revealed a diagnosis of end stage renal failure on hemodialysis [Monday, Wednesday, and Friday]. Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating his cognitive was moderately impaired. Record review of Resident #5's care plan dated 05/17/24 revealed a focus area for renal failure requiring dialysis with goal of will have no signs and symptoms complications from dialysis and interventions of check access site for bruit and thrill, coordinate medication schedule with MD to prevent medications from being flushed during dialysis, observe and report to Nurse &/or MD PRN any signs/symptoms of infection to access site, observe/document and report to Nurse/MD PRN for signs and symptoms of renal insufficiency. The care plan did not include maintaining communication with dialysis center. Record review of Resident #5's dialysis communication forms for month of April 2024 revealed: 4/26/24 - dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Record review of Resident #5's dialysis communication forms for month of March 2024 revealed: 5/6/24 - dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/8/24- dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 5/13/24- dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 5/15/24- dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 5/20/24- dialysis center information which included: vital signs, pre-weight, post weight, dialysis start time, dialysis end time, fluid removed, meal/snack intake, shunt location/status, new MD orders/recommendations, and additional information was left blank. Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 5/27/24- Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. Record review of Resident #5's dialysis communication forms for month of June 2024 revealed: 6/3/24- Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 6/14/24- Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 6/17/24- Post dialysis information which included: date, time, vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. 6/19/24- Post dialysis information which included: vital signs, shunt location/status, bruit/thrill present, bleeding, general condition of resident and nurse signature, was left blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/24 at 1:38 pm, LVN E stated she was the charge nurse responsible for Resident #5 and stated he had dialysis scheduled 3 times a week on Mondays, Wednesdays, and Fridays. LVN E stated she was responsible for initiating the dialysis form for residents to take with them to their appointments which included Resident #5's last set of vitals taken prior to departure, date and time, medication list attached, physician name, meal/snack sent with him, location of shunt, and her signature. LVN E stated the dialysis communication form was the source of communication between facility and dialysis center. LVN E stated the afternoon charge nurse was responsible for ensuring the communication form was completed by the dialysis center and complete the post dialysis information. LVN E stated it was expected for the dialysis center to complete their section and if not completed, they were trained to report to the DON and/or call dialysis to follow up. LVN E stated she could not recall if the facility had provided training regarding dialysis care in general, but it was part of their nursing school training. LVN E stated she was not aware Resident #5's dialysis forms had not been properly completed on several occasions due to her working the morning shift. During an interview on 6/26/24 at 2:11 pm, Dialysis RN stated the dialysis communication form was the source of communication between the facility and dialysis center. The Dialysis RN stated the intent for the communication form was to maintain communication and monitor the resident's status from beginning to end of treatment to when they returned to the facility. The Dialysis RN stated the dialysis center tried their best to keep up with the forms but it was difficult at times. The Dialysis RN stated the center had not received any calls from the facility following up on lack of documentation on their end. The Dialysis RN stated by the dialysis center not filling out their portion in the communication form, the possibility of the facility missing a change in condition. The Dialysis RN stated when a resident had a significant change in condition that required hospital evaluation, the dialysis center would call the facility to notify them. During an interview on 6/26/24 at 2:40 pm, LVN F stated she recently started working the afternoon shift 2p-10p. LVN F stated she was the charge nurse for Resident #5 in the afternoon shift. LVN F stated Resident #5 had the late shift dialysis appointment due to his exposure to Covid-19. LVN F said she received training regarding dialysis care upon hire, including completing the dialysis communication form. LVN F stated she had not noticed discrepancies in the dialysis forms she had seen. LVN F stated if she noticed the dialysis center part of the communication was not filled out, she would reported to the DON and called the dialysis center to follow up. LVN F said the risk of the form being completed accurately could miss a change in condition. During an interview on 6/26/24 at 2:48 pm, the DON stated she had not noticed the discrepancies with dialysis communication forms until she had submitted them to Surveyor. The DON stated she had started with the facility about 2 months ago and nobody had reported issues with the dialysis communication forms. The DON stated it was expected for the afternoon nurse to ensure the communication form was accurately completed by the dialysis center and complete the post dialysis portion. The DON stated the risk could be lack of monitoring and possible miss a change in condition. The DON stated she did not know the training the previous nursing administration had provided and stated the current staff were practically new. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tierra Este Nursing and Rehabilitation Center	14300 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of hemodialysis policy dated 06/2022 read in part This facility will provide care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of receiving hemodialysis. Compliance guidelines: the licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as dialysis communication form or other form, that will include, but not limit itself to: B- physician/ treatment orders, laboratory values, and vital signs; D- nutritional/ fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals, during and/or after dialysis and monitoring intake and output measures as ordered; F- dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular site.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43871 Based on interview and record review, the facility failed to ensure the facility assessments were documented and facility-wide assessments determined what resources were necessary to care for residents competently during both day-today operations and emergencies for 1 of 1 facility reviewed for facility assessment. The facility failed to ensure the assessment contained information about the level of staff needed to meet each resident's needs. This failure could place residents at risk of inadequate care of treatment. Findings included: Record review of facility's assessment was dated 04/24/23 and the facility budget staffing plan was blank. During an interview on 06/28/24 at 9:13 am, the DON stated she received an email about 2 weeks ago from the Administrator regarding completion of the facility assessment. The DON stated she was aware that facility assessment was overdue and was currently still working on completing her section (staffing). The DON stated the Administrator was the person responsible for ensuring the facility assessment was completed in the month that the year was up. The DON stated she did not know why the facility assessment had not been completed yet. During an interview on 06/28/24 at 2:03 pm, the Administrator stated the facility assessment should be completed annually. The Administrator stated based on facility assessment policy she was out of compliance. The Administrator stated she used to have a corporate interim DON who was completely worthless, and it was not completed. She opted to wait to bring on new the DON. The Administrator stated she did not remember if she notified corporate of concerns related to previous corporate interim DON that resulted in delay of facility assessment completion. The Administrator stated the only risk was that the facility did not have, in writing, their plan for the staffing ratio. Record review of the Administrator E-mail sent out to the department heads dated 06/18/24, revealed, I am sharing the annual facility assessment template that we are required to conduct on a yearly basis. Please review and fill out any areas pertaining to your department date. Record review of Facility assessment policy dated 07/2022 read in part This facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents completely during both day to day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for any changes that would require a substantial modification to any part of the assessment. Additionally, the facility will consider specific needs for each shift and for each resident unit in the facility based on changes to resident population. Any changes to the assessments will be documented, along with a revision history

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review, the facility failed to ensure medical records were maintained on each resident that were complete and accurately documented for 3 of 5 (Resident #1, #4 and Resident #2) reviewed for accuracy and completeness of medical records. 1. The facility failed to document the event of Resident #2's allegation of being called stupid and handled rough when ADLs were being performed in the facility progress notes and conduct an incident report. 2. The facility failed to have complete and accurate documentation for a resident to resident altercation between Residents #1 and #4 on 06/23/24. These failures could place residents at risk of not receiving needed service. Findings included: Record review of Resident #2's face sheet dated 06/25/24, revealed, admission on 12/30/22 and re-admission on 09/02/23 to the facility. Record review of Resident #2's facility history and physical dated 09/28/23, revealed, a [AGE] year-old female diagnosed with Diabetes Mellitus, kidney disease stage 2, COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), respiratory failure, right hemiplegia (paralysis to one side of the body), quadriplegia (paralysis of all four limbs), Cerebrovascular accidents (an interruption in the flow of blood to cells in the brain), and osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time). Record review of Resident #2's quarterly MDS dated [DATE], revealed, a moderate impairment of cognition BIMS score of 11 to be able to recall or make daily decisions. Resident #2's ADLs for toileting and baths were dependent on nursing staff for assistance. Dressing and putting on footwear required substantial/maximal assistance from staff (staff does more than half the effort to help). Resident #1 was dependent (Staff do all the effort while assisting) on staff for toilet transfer, chair/bed-to-chair transfer, tub/shower transfer. Lying to sitting on side of bed, sit to stand, and sit to lying required substantial/maximal assistance from staff. Record review of Resident #2's care plan dated 09/28/23, revealed, Resident #2 had the potential for self-care deficit and decline in ADLs due to history of Cerebrovascular accidents (an interruption in the flow of blood to cells in the brain) with functional quadriplegia and Aspasia (loss of ability to understand or express speech, caused by brain damage). Provide assistance for mobility, dressing, eating, toileting, personal hygiene, oral care, bathing as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 9:00 AM, with the Administrator, she stated Resident #2 had reported that the nurse that CNA B had been a little rough when getting her up and had called her stupid. The Administrator stated that CNA B was suspended pending the outcome of the investigation. The Administrator stated it should have been documented in the progress notes and an incident report done and none were done for Resident #2's incident. Record review of Resident #2's progress notes dated 01/25/24-02/13/24, revealed there was no indication of a report by Resident #2 indicating that CNA B had called her stupid or been rough during ADLs. Record review of Resident #1's face sheet dated 06/25/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #1's progress note dated 06/23/24 written by LVN A revealed Nurse responded to call from resident [Resident #1]. He claims his neighbor bumped him with his WC. When this nurse went to assess the situation, [Resident #4] stated that resident [Resident #1] hit him with a pole. Inspection of [Resident #4] was negative for bruising or redness. [Resident #4] stated that he was trying to pass by [Resident #'1s] bed. He stated the pass way was blocked by [Resident #1] WC and accidently bumped the WC, The WC then bumped into [Resident #1] side. As a result. [Resident #1] struck [Resident #4] with a pole. Resident [Resident #4] denies and pain or discomfort. Nurse called ADON and informed her of situation. ADON advised to move [Resident #4] to room [ROOM NUMBER]B for safety precautions. Record review of Resident #1's progress note dated 06/24/24 written by DON revealed Spoke to resident [Resident #1] regarding last night incident with roommate. resident state he only tapped resident with cane to get his attention since roommate was moving his wheelchair. Educated resident on not using cane or any other equipment to get any residents attention. Canes removed from room for safety. resident in understanding. Emergence Caseworker will be in to speak to resident as well. Record review of Resident #1's progress note dated 06/24/24 revealed resident picked up at 1640 (4:40 pm) for transport to local behavioral unit. Complaint with transfer onto stretcher and all paperwork sent with EMT's. Signed consent with paper work. Record review of Resident #4's face sheet dated 06/25/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #4's BIMS assessment dated [DATE] revealed a BIMS score of 1, indicating his cognitive was severely impaired. Record review of Resident #4's progress notes dated 06/23/24 revealed no assessment documented regarding resident-to-resident altercation. Record review of Resident #4's assessments dated June 2024 revealed no skin assessment completed on 06/23/24 for resident-to-resident altercation. During an interview on 06/25/24 at 9:39 am, Resident #4 was alert and oriented to person only. Resident #4 denied any concerns with roommate and denied any resident-to-resident altercation. Resident #4 did not show signs of distress. Resident #4 stated he felt safe in the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/24 at 10:05 am, a call was placed to Resident #1 listed number. There was no answer and left VM to return the call. The call was not returned by date and time of exit on 6/28/24. During an interview on 06/25/24 at 10:07 am, a call was placed to Resident #1 second listed phone number listed. A voice mail was not set up and Surveyor was not able to leave voicemail. During an interview on 06/25/24 at 10:08 am, Case Manager stated he was aware of the incident that occurred on 06/23/24. The Case Manager stated he had been notified by a nurse that Resident #1 had become upset and hit Resident #4 with a cane. The Case Manager stated he visited Resident #1 on Monday 06/24/24 and spoke to Resident #1 in which he had denied hitting Resident #4 and had stated he had only tapped Resident #4 with the cane. Case Manager stated he had asked Resident #1 for permission to review the camera footage. The Case Manager stated in the video footage the Social Worker, DON and himself were able to see that Resident #4 had passed by to get to the restroom and on his way back to his bed, Resident #1's wheelchair was in the way. Resident #4 was seen trying to move the wheelchair in attempts to get to his side of the room and Resident 31 became upset. Resident #1 then grabbed his cane and swung at Resident #4 because of the placement of the camera and the privacy curtains they were unable to determine if Resident #1 had hit Resident #4. The Case Manager stated Resident #1 was seen swinging and aimed the cane towards Resident #4 in attempts to hit him. The Case Manager stated Resident #1 had been transferred to local behavioral unit for further evaluation and hopefully medication adjustment. The Case Manager stated it was the first time he had known Resident #1 to have a physical aggression outburst. During an interview on 06/25/24 at 11:14 am, LVN E stated he had worked on 06/23/24 and was the nurse that had responded to Resident #1 and Resident #4 altercation. LVN E stated he heard Resident #1 call out for him for assistance. LVN E stated when he arrived at Resident #1 room, Resident #1 had told him Resident #4 had been bumping into his wheelchair and Resident #4 had stated he had been hit with a pole. LVN E stated Resident #4 stated he had been hit on his upper right extremity. LVN E stated he separated both residents to provide Resident #4 safety. LVN E stated he reported the incident to ADON. LVN E stated he documented the incident in progress notes but did not complete an incident report. LVN E stated he did not complete an incident report because he was not told to do so. During an interview on 06/25/24 at 11:32 am, a call was placed to Resident #4's RP. There was no answer, and a voicemail was left with information to return the call. The call was not returned by date and time of exit on 6/28/24. During an interview on 06/25/24 at 1:54 pm, ADON stated she had been notified by LVN E on 06/23/24 late night regarding Resdient #1 and Resident #4 altercation. ADON stated she had instructed LVN E to separate both residents to provide safety to Resident #4 and continue to monitor. ADON stated LVN E had completed an assessment for the facility to continue to monitor. ADON looked for alleged assessments completed by LVN E and could not locate them on the electronic records. ADON stated the risk for not competing incident report per policy was inaccurate details of incident, lack of monitoring, lack of people notified i.e., RP and NP/MD. ADON stated an incident report should had been completed for Resident #1 and Resident #4. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/24 at 2:30 pm, the DON stated an incident report had not been completed by LVN E. The DON stated nursing administration were responsible for ensuring incident reports were completed in a timely manner by the charge nurse who witnessed and/or attended to the alleged incident. The DON stated by not completing the incident reports the facility could not prove the alleged actions taken took place and lack of monitoring. Record review of Incidents and Accidents policy dated 07/2022 read in part It is the policy of this facility for staff to utilize Risk Management in PCC to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Compliance guidelines: 1- incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information. 5- the following incidents/accidents require an incident/accident report but are not limited to: resident to resident altercations. Record review of Documentation in Medical Record policy dated 12/2022 read in part each resient's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public for 1 of 5 resident rooms reviewed for environment. The facility failed to ensure the broken window in room [ROOM NUMBER] was fixed. This failure could place residents at risk of living in an unsafe environment which may create a potential for a cut, insect bites, or respiratory problems. Findings included: Record review of Resident #7's vitals for oxygen dated 06/02/24-06/25/24, revealed, oxygen saturation to be between 92 percent to 97 percent saturation. Record review of Maintenance Director text message that was provided dated 01/26/24, stated the following: Maintenance Director - Good afternoon, President we need a window replacement asap please. Text message dated 01/30/24 - Maintenance Director - Good morning, President any news for window replacement yet? Text message dated 01/31/24 - President - Ok they are working on getting the order placed and I will update you as I get information on it. During an interview on 06/25/24 at 9:07 AM, with the Ombudsman, he stated in hallway 100 there was a broken window that was covered up with cardboard. The Ombudsman stated it was a concern of the Resident #4. The Ombudsman stated he noticed it last month (June 2024) when he went to visit the residents of the facility but was not sure if had been fixed. Observation and interview on 06/25/24 at 1:23 PM, with Resident #7 revealed, in room [ROOM NUMBER] - there was a broken double-sided window with cardboard placed on the broken window (interior window that was broken) and had been taped to the window. A big whole could be seen with cracks on its bottom left-hand and upper right-hand sides of the window. There was a trash bag placed on the outside of the broken window but on the inside of the seconded unbroken window. Resident #7 was placed closet to the window. Resident #7 was on oxygen and had a nasal cannula on with the concentrator on. Resident #7 stated the air and dust goes into the room from the broken window. Resident #7 stated when it does go in, he has trouble breathing and sneezes a lot more. Resident #7 has a roommate was always on oxygen as Resident #8 was asleep in his bed with the nasal cannula on and the concentrator on. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/24 at 1:23 PM, with the DON, she stated she had heard the window was broken in room [ROOM NUMBER]. The DON stated that was before she had started working (May 2024) for the facility. The DON stated she did not know who broke the window but had seen it. The DON stated there was a risk to the residents depending on the weather such as dust, wind, insects coming into the room/facility. Observation and interview on 06/25/24 at 1:57 PM, with Maintenance Director, he stated a resident had punched the window and broke it. The Maintenance Director stated the interior window was broken but not the exterior window was not. The Maintenance Director stated he contacted the builder of the facility to try to get the window fixed as it still had warrant. The Maintenance Director was told that it was going to be special ordered. The Maintenance Director stated the builder had told him once they receive the window that he would send someone to go and install the new window. The Maintenance Director stated the builder keeps telling him he was waiting for the window to come. The Maintenance Director stated it was reported to the President of the facility to try and get the window. The Maintenance Director stated he notified the Administrator and then the Administrator notifies the President. The Maintenance Director stated the interior window was covered with cardboard and plastic. The Maintenance Director stated the risk to the residents would be cutting themselves on the window. The Maintenance Director revealed text messages from the builder to the Maintenance Director dated 01/26/24, revealing, that the window had been broken. Observation and interview on 06/27/24 at 1:54 PM, with Resident #7, he stated to much dirt comes into the room and feels the dust. Resident #7 stated when the wind blows hard you can feel it. Window had cardboard and plastic bag taped to the interior window. Window was not replaced and still broken. During an interview on 06/28/24 at 2:03 PM, with the Administrator, she stated the window had been reported serval months ago that it had been broken. The Administrator stated the outside window (exterior window) was not broken only the inside window. The Administrator stated the inside of the broken window had been cleaned out and she had verified that it had been done. The Administrator was shown a photo taken on 06/25/24, of the broken window with glass still in the window seal. The Administrator stated there was a work order placed for the broken window. The Administrator stated the builder was called and a quote was given for the replacement window. The Administrator stated to go ahead and fix the window. The Administrator stated she had talked to the builder the day before yesterday (06/26/24) and were told we had to make arrangements to have it ordered. The Administrator stated the facility not knowing they had to make arrangements to have it ordered prolonged the broken window from being fixed for months. The Administrator stated there was one resident who she could not remember the name had complaint about the broken window. The Administrator stated he did not like the cardboard, the dust and wind coming in, and was moved from the room. The Administrator stated no other resident had complained since then. The Administrator stated the risk was leaking air or sand, cool air or hot air, into the room, a resident cutting themselves. Record review of the facility Safe and Homelike Environment policy not dated, revealed, Policy-It accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the residents can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose s safety risk. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility in-voice dated 02/08/24, revealed, Horizontal slider window quoted for President.