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	02/20/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interviews, and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infections for 1 of 2 (Resident #2) residents reviewed for quality of care. The facility failed to ensure Resident #2's wound vac setting was set at 115mmhg as ordered by the physician. This deficient practice could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds. The findings included: Record review of Resident #2's face sheet dated 12/21/24 revealed a [AGE] year-old male with diagnoses of sepsis (life-threatening emergency that happens when your body's response to an infection damages vital organs and, often, causes death), pressure ulcer to sacrum, and hemiplegia (paralysis on one side of the body). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 4, indicating his cognition was severely impaired and had pressure ulcers. Record review of Resident #2's physician order dated 2/11/25 revealed wound care to sacrum stage 4 pressure cleanse with Dakin's with normal saline pat dry apply wound vac with granulated foam secure with Tegaderm and set negative pressure continuously at 115mmhg every Monday, Wednesday, and Fridays. Record review of Resident #2's care plan dated 2/19/25 revealed a focus area for pressure ulcer stage 4 to sacrum with interventions that included administer treatments as ordered and monitor effectiveness. During an observation and interview on 2/19/25 at 11:23 am, Resident #2 was in bed facing the door with wedges under his right torso, he was alert and oriented to person and event. Resident #2 denied any concerns with his wound care and denied any discomfort. Resident #2's wound vac was set at 125mmhg . Resident #2 stated he did get wound care treatment and stated it was almost every day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/19/25 at 3:35 pm, Resident #2 was in bed facing the window with pillows under his left torso and denied any discomfort to wound. The DON stated Resident's wound vac was set at 125mmhg. The DON stated local supply store delivered the wound vac on 2/11/25 and set the rate settings. The DON stated it was expected for the nurses to check the wound vac during wound care to ensure the settings were as ordered. The DON stated she was the nurse who had provided wound care to Resident #2 in the morning (2/19/25) and did not check the wound vac settings. The DON stated the wound vac was supposed to be set at 115mmhg. The DON stated the risk included increased bleeding from suction . During an observation and interview on 2/20/25 at 9:30 am, Resident #2 denied and pain/discomfort to his wound. The ADON assisted him in repositioning to his right side to face the window. The wound vac dressing was slightly lifting on one edge and was dated 2/19/25. ADON noted less necrotic tissue, granulation present, minimal drainage, some slough around the area, and no signs of infection. During an interview on 2/20/25 at 3:16 pm, The Doctor stated that there were no concerns regarding Resident #2's sacral wound at that time. T The Doctor stated there had been no indication of increased drainage or infection. The Doctor stated that the nursing staff was expected to follow the treatment orders as written. The Doctor stated that for not setting the wound vac settings as ordered were increased drainage, discomfort, and pain. During interview on 2/20/25 at 4:46 pm, the Administrator stated she would refer the wound care treatment to the DON. Record review of the facility's policy Wound Treatment Management dated 07/2022 read in part wound treatments will be provided in accordance with physicians orders, including the cleansing method, type of dressing, and frequency of dressing change . The facility did not have a policy specifically for the wound vac management.