STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676342	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST. TERESA NURSING AND REHABILITATION CENTER	10350 MONTANA AVENUE EL PASO, TX 79925

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to accurately assess 1 (Residents #42) of 9 residents whose assessments were reviewed as evidenced by: A. Resident #42 did not have his [DIAGNOSES REDACTED]. This failure could place residents at risk of not receiving the necessary care and services required to meet their needs. The findings included: A. Resident #42 Review of the face sheet dated 3/12/20 documented Resident #42 was a [AGE] year-old man admitted on [DATE] with an initial admission date of [DATE]. Review of the Physician's Progress Note dated 3/5/20 documented Resident #42 had [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] revealed Resident #42 had minimal difficulty hearing, unclear speech, rarely or never understood, understood others, and had impaired vision. He was documented as having a memory problem and severely impaired daily decision making. The active [DIAGNOSES REDACTED]. Review of Resident #42's Care Plan dated as last revised 3/12/20 documented that the resident had impaired cognitive function/dementia or impaired thought processes. Observation on 3/10/20 at 8:35 AM in Resident #42's room revealed the resident resting in his bed. Resident uninterviewable, observed free of signs or symptoms of distress covered with a blanket. In an interview on 03/12/20 at 09:29 AM LVN B stated that she was familiar with Resident #42's care. Stated that Resident #42 had left sided [MEDICAL CONDITION] and was bed bound. She continued by stating the resident had history of stroke and was oriented to self only. She further explained that staff communicate with resident via simple yes or no questions. In an interview on 03/12/20 at 02:42 PM MDS Coordinator A Stated she was responsible for having conducted Resident #42's MDS. When asked how she had been trained to list active [DIAGNOSES REDACTED]. She stated she did not know why the resident's [DIAGNOSES REDACTED]. In an interview on 03/12/20 at 02:59 PM Regional Reimbursement Staff F, stated she give guidance to MDS nurses in the facility or they can call a corporate hotline for guidance when conducting MDS assessments. She explained that the active [DIAGNOSES REDACTED]. She stated that nurses can get this information by reviewing physician progress notes [REDACTED].#42's [DIAGNOSES REDACTED]. Review of an undated facility policy titled Resident Assessment revealed, in part, that: The assessment will include at least the following: Medically defined conditions and prior medical history.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for 2 (Residents #41 and #46) of 24 residents whose care plans were reviewed. A. Resident #41 required oxygen via nasal cannula but there was no care plan for provision of this service B. There was no care plan for activities for Resident #46. This failure could place residents at risk for not having physical, emotional or spiritual needs met. The findings included: A. Resident #41 Review of Resident #41's Admission Record dated 03/11/2020 documented that she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #41's physician History and Physical dated 03/05/2020 documented that she had [DIAGNOSES REDACTED]. Review of Resident #41's admission MDS dated [DATE] documented that she had a BIMS of 7 (Severe Cognitive Impairment). She required extensive assistance from one or two people for most of her activities of daily living. She was not receiving oxygen therapy. Review of Resident #41's discharge MDS dated [DATE] documented that she was unable to complete the BIMS interview and that staff assessed her as has having memory problems and some difficulty in making daily decisions in new situations. She was not receiving oxygen therapy. Review of Resident #41's MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of Resident #41's MAR for 03/01/2020 through 03/31/2020 documented an order to check her oxygen saturation level every shift. Saturation levels were documented from night shift on 03/06/2020 through the day shift of 03/10/2020. There was an order for [REDACTED]. Review of Resident #41's Order Recap Report dated 03/11/2020 for orders dated 01/28/2020 through 03/31/2020 documented an order for [REDACTED].#41 on 03/10/2020 at 2:29 PM revealed that the resident was laying in bed. An oxygen concentrator was to the left of her bed with a nasal cannula and tubing attached. A family member at her bedside was not sure who had removed her nasal cannula. In an interview on 03/11/2020 at 2:40 PM LVN A stated that she was not sure if Resident #41 should be wearing the nasal cannula. Observation on 03/11/2020 at 3:00 PM revealed that LVN A replaced the oxygen cannula from the concentrator with a new one and checked the Resident #41's blood oxygen level. Review of Resident #41's Care Plan dated 02/06/2020 (Last Care Plan Review) documented no care plan for oxygen for Resident #41. On 03/12/2020 at 2:25 PM in an interview ADON D stated that there should be a care plan for oxygen for Resident #41. B. Resident #46 Review of the admission MDS dated [DATE] revealed Resident #46 was a [AGE] year-old male admitted on [DATE]. Resident #46 had a BIMS score of 9 (moderate cognitive deficit for daily decision-making) , no behaviors, does not indicate any preferred activities in Section F, is dependent on staff for transfers/dressing/eating/bathing and required extensive assist for toilet use and bed mobility. Review of the facility History and Physical dated 1/26/2020 documented Resident #46 had [DIAGNOSES REDACTED]. Review of the comprehensive care plan for Resident #46 revealed there was no care plan for activities. Observation on 3/10/2020 at 2:23 PM revealed Resident #46 was in bed and turned to his left side. His arms and legs were straight and did not move. He had a healed [MEDICAL CONDITION] stoma. He had a touch pad call light that was next to his head. Resident #46 had an indwelling urinary catheter. His wife was at the bedside. He was alert, oriented and interviewable. In an interview on 3/10/20 at 2:23 PM, Resident #46 said the pressure ulcer on his bottom made it too uncomfortable to sit in a chair. His wife said he is too stiff and does not bend well so he does go to activities. He has a TV in his room but said he did not do anything else. He said nothing was brought to his room like music. In an interview on 3/12/20 at 3:56 PM, MDS Coordinator D said if the care area activities was triggered on the CAA, and the Care Planning Decision is checked, like it is on Resident #46's MDS Section V, then there is supposed to be a care plan for that area. In an interview on 3/12/20 at 4:02 PM, the DON said Resident #46 stays in his room. She said it was very important for him to have activities even though his wife is always with him. The DON said the Activities Director has not told her that they do not provide activities because the wife is in the room. The DON said activities should be care planned. Review of the facility policy Activity Care Planning dated 2011 stated in part: The care plan is completed within 7 days after completion date if the RAI (Resident Assessment Instrument) process. (The MDS) The care plan addresses the problems/needs/concerns, strengths and preferences identified in the comprehensive assessment process as necessary issues to be care planned. Review of the facility policy Comprehensive Care Planning undated, stated in part that each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals and address the resident's medical, physical, mental and psychological needs.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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.

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview and record review the facility failed to provide an ongoing program of individual activities for 2 (Residents #46 and #102) of 24 residents reviewed for activities. Residents #46 and #102 were not provided in room activities. This failure could place residents at risk for not having physical, emotional or spiritual needs met. The findings included: Review of the admission MDS dated [DATE] revealed Resident #46 was a [AGE] year-old male admitted on [DATE]. Resident #46 had a BIMS score of 9 (moderate cognitive deficit for daily decision-making), no behaviors, does not indicate any preferred activities in Section F, is dependent on staff for transfers/dressing/eating/bathing and required extensive assist for toilet use and bed mobility. Review of the facility History and Physical dated 1/26/2020 documented Resident #46 had [DIAGNOSES REDACTED]. Review of the comprehensive care plan for Resident #46 revealed there was no care plan for activities. Review of Daily Logs for Activities 2020 did not have an activity record for Resident #46 and did not have him listed on any of the activities listed for March 2020. . Review of the activity department's Individualized One-to-One Programming had 1 record of an activity for Resident #46. On 2/20/20 Resident #46 had an activity talk for 15 minutes. No other records were provided for Resident #46. Observation on 3/10/2020 at 2:23 PM revealed Resident #46 was in bed and turned to his left side. His arms and legs were straight and did not move. He had a healed [MEDICAL CONDITION] stoma. He had a touch pad call light that was next to his head. Resident #46 had an indwelling urinary catheter. His wife was at the bedside. He was alert, oriented and interviewable. In an interview on 3/10/20 at 2:23 PM, Resident #46 said the pressure ulcer on his bottom made it too uncomfortable to sit in a chair. His wife said he is too stiff and does not bend well so he does go to activities. He has a TV in his room but said he did not do anything else. He said nothing was brought to his room like music. In an interview on 3/12/20 at 1:53 PM, the Activities Director said both Resident #46 and his wife go to the big activities with music or the matachinas on Sundays. She said she does not keep records for group events. She later said the Daily Log for Activities is a log of the activities held. Whoever comes to the activity is listed and their response is documented. The Activity Director said, after she looked at the Individualized One-to-One Programming records from November 2019 through January 2020 and Resident #46 was not listed. In an interview on 3/12/20 at 4:02 PM, the DON said Resident #46 stays in his room. She said it was very important for him to have activities even though his wife is always with him. The DON said the Activities Director has not told her that they do not provide activities because the wife is in the room. The DON said activities should be care planned. Resident #102 Review of the admission MDS dated [DATE] documented Resident #102 was a [AGE] year old male admitted on [DATE]. The MDS revealed Resident #102 had a BIMS score of 15 (no cognitive deficit for daily decision-making), no behaviors, activity preferences listed as very important was going outside and somewhat important was reading material, news, music, and groups, dependent on staff for eating and baths, required extensive assist for bed mobility, transfers, dressing and toilet use. Review of the facility History and Physical dated 9/29/19 revealed Resident #102 had [DIAGNOSES REDACTED]. Review of Resident #102's care plan dated 12/16/19 revealed the following: The resident is dependent on staff for activities, cognitive stimulation, social interaction related to immobility. The goal was the resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions included all staff will converse with resident during care. Review of Daily Logs for Activities 2020 did not have an activity record for Resident #102 and did not have him listed on any of the activities listed for March 2020. . Review of the activity department's Individualized One-to-One Programming did have any activities listed for Resident #102 from November 2019 through March 2020. Observation on 3/11/2020 at 10:18 AM revealed Resident #102 was in bed. He was not able to move his arms or legs. He had a pneumatic call light at his bedside that his wife positioned for him to use. He had a [MEDICAL CONDITION] with a speaking valve. In an interview on 3/11/20 at 10:18 AM, Resident #102 said he has had no activities outside of TV. He said nothing is brought to him in his room, not even music. In an interview on 3/12/20 at 1:16 PM, LVN E said Resident # 102 was not able to go to activities. She said he cannot participate as he cannot move his hands or feet. In an interview on 3/12/20 at 2:03 PM, the Activity Director said for those residents who do not come out of their room, like Resident #102 and others on the 400 hall, they do aromatherapy and pet therapy. She said they have had to stop their volunteers from schools and churches due to the [MEDICAL CONDITION] precautions. In an interview on 3/12/20 at 4:02 PM, the DON said she did not remember Residents #102 coming out of his room. Because of his condition it was very important to have activities even though his wife is always with him. Review of the facility policy Individualized Activity Programs dated 2019 stated in part the Activity Director and staff will provide individual programming to meet individual needs and interests. One on one activities are provided regularly for those residents unable or unwilling to attend groups unless otherwise indicated by assessment. Individual programs are coordinated by the Activity Director, or designee, maintained and documented in the plan of care.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable for 1 (nurse medication cart on the 200 hallway) of 3 medication carts reviewed. The [MED] [MED] pen for Resident # 206 did not have a label on it. The [MED] inhaler for Resident #205 was not labeled when opened. This failure could place residents at risk for cross contamination or for medications that have expired. The findings included: A. Resident #206 Review of the face sheet dated [DATE] documented Resident #206 was a [AGE] year old female admitted on [DATE]. Review of the facility History and Physical dated [DATE] documented Resident #206 had [DIAGNOSES REDACTED]. Review of the Order Summary Report dated [DATE] revealed physician orders for [MED] [MED] Solution Pen-Injector 100 units/ml ([MED] [MEDICATION NAME]) Inject 25 units subcutaneously one time a day for DM. Observation and interview on [DATE] at 8:07 AM, with LVN C, revealed an [MED] pen in the medication cart for the 200 hallway. The pen was [MED]. It did not have a label or a resident name on the pen but the date of [DATE] was written on the pen. LVN C said the [MED] pen was for resident #206. In an interview on [DATE] at 2:10 PM, LVN C said when meds are taken out of the emergency supply, they are supposed to be labeled with the resident's name and room number. In an interview on [DATE] at 4:15 PM, the DON said the nurse got the syringe from the E-kit. The pen should have been labeled with the resident's name. Review of the facility policy Medication Labeling dated 2003 revealed in part that medications are labeled in accordance with facility requirements and state and federal laws. All legend patient medications regardless of source shall be properly labeled as required in State regulations for Long Term Care Facilities. (A legend drug is a drug approved by the U.S. Food and Drug Administration that can be dispensed to the public only with a prescription from a medical doctor or other licensed practitioner.) B. Resident #205 Review of the face sheet dated [DATE] documented Resident #205 was an [AGE] year old female admitted on [DATE]. Review of the Resident #205's Order Summary Report dated [DATE] documented [DIAGNOSES REDACTED]. There was a physician order for [REDACTED]. There was no date on the inhaler or the box with the date it was opened. LVN C said Resident #205 came from the 400 hall with the [MED] already in use but she should have checked it for a date it was opened since it is good for 58 days. Review of the Patient Information for the [MED] Inhub at https://dailymed.nlm.nih.gov on [DATE] revealed the [MED] Inhub should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard [MED] Inhub 1 month after opening the foil pouch or when the counter reads 0 (after all doses have been used), whichever comes first. The inhaler is not reusable. Do not attempt to take the inhaler apart.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for food safety. One dented can of fruit was observed in the supply of canned goods marked for use in the facility. One of one bucket of sanitizer in the kitchen was not properly diluted with water. This failure could place residents at risk for food-borne illnesses. The findings include: Canned goods: Observation on 03/11/2020 at 03:53 PM revealed one canned food item with a dent in the rim of the

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) can and a bulge on the lid next to the dented rim of the can. It was observed in the dry storage on a rack with other canned goods designated for use in meal preparation. Upon asking the Dietary Service Manager about the can, he inspected it and removed the can, setting it aside onto a rack with other cans marked do not use. Interview on 03/11/2020 at 03:54 PM The Dietary Service Manager stated that employees are trained and expected to separate any canned food items with dents from undented cans. He stated that cans with dents or bulging, especially around or along the lid are at risk for being contaminated and could put residents at risk. Sanitizer: Observation and interview on 03/11/2020 at 4:01 PM with the Dietary Service Manager revealed the kitchen had one red bucket marked for sanitizer solution. The Dietary Service Manager was asked to test the solution to check the strength of the sanitizer in the solution. The Dietary Service Manager utilized a test strip, dipped it into the solution and swirled it around. Upon removing the test strip, it was laid against the test kit key to observe the total PPM of the sanitizer in the solution. The strip was observed reading less then 100 PPM. The Dietary Service Manager stated that the solution should read at least 100 PPM and proceeded to empty the bucket and remake the solution. In an interview on 03/12/2020 at 12:26 PM the Dietary Service Manager stated that sanitizer solution needed to have a PPM of sanitizer solution to water of at least 100 PPM. The Dietary Service Manager further stated that the risk of utilizing inadequately prepared sanitizer solution would be the failure to sanitize working surfaces and equipment in the kitchen. The Dietary Service Manager concluded that this would place residents at risk of exposure to food borne illness. Review of the undated Infection Control Dietary Service Policy documented in part that: All kitchenware and food contact surfaces will be cleaned and sanitized after each use. Fresh clothes and sanitizer will be used for cleaning all surfaces. Sanitizer will be minimum of 100 PPM chlorine or 25 PPM iodine or 150-400 quaternary ammonia - tested using an approved kit.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Residents #41 and #155) of 24 residents reviewed for infection control. A. Resident #41's unprotected nasal oxygen cannula was draped over the oxygen concentrator next to her bed. B. Resident #155's indwelling catheter drainage bag and bag drain were laying on the floor. These failures could put residents at increased risk of exposure to infections and communicable diseases. Findings include: Resident #41 Review of Resident #41's Admission Record dated 03/11/2020 documented that she was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #41's physician History and Physical dated 03/05/2020 documented that she had [DIAGNOSES REDACTED]. Review of Resident #41's admission MDS dated [DATE] documented that she had a BIMS of 7 (Severe Cognitive Impairment). She required extensive assistance from one or two people for most of her activities of daily living. She was not receiving oxygen therapy. Review of Resident #41's discharge MDS dated [DATE] documented that she was unable to complete the BIMS interview and that staff assessed her as having memory problems and some difficulty in making daily decisions in new situations. She was not receiving oxygen therapy. Review of Resident #41's MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of Resident #41's MAR for 03/01/2020 through 03/31/2020 dated 03/10/2020 documented an order to check her oxygen saturation level every shift. Saturation levels were documented from night shift on 03/06/2020 through the day shift of 03/10/2020. There was an order for [REDACTED]. Review of Resident #41's Order Recap Report dated 03/11/2020 for orders dated 01/28/2020 through 03/31/2020 documented that the orders to change oxygen equipment and clean the oxygen filter were received on 03/06//2020. an order for [REDACTED].#41 on 03/10/2020 at 2:29 PM revealed that she was lying in bed. An oxygen concentrator was to the left of her bed with a nasal cannula and tubing attached. The nasal cannula was not covered. In an interview on 03/10/2020 at 2:29 PM Resident #41's family member who was at her bedside stated she did not know who took the nasal cannula off the resident. In an interview on 03/11/2020 at 2:40 PM LVN A stated that she was not sure if Resident #41 should be wearing the nasal cannula, but that the cannula should be in a plastic bag because there was increased risk of infection to the resident if the cannula was exposed. Observation on 03/11/2020 at 3:00 PM revealed that LVN A replaced Resident #41's oxygen cannula from the concentrator with a new one and checked the Resident #41's blood oxygen level. LVN A put the cannula in a plastic bag. Review of Facility Policy Oxygen Administration revised 02/13/2007 documented that it did not address covering the nasal cannula when not in use. B. Resident #155 Review of the face sheet dated 3/12/2020 documented Resident #155 was a [AGE] year old female admitted on [DATE]. Review of the facility History and Physical dated 3/07/2020 documented Resident #155 had [DIAGNOSES REDACTED]. Review of Resident #155's Order Summary Report dated 3/12/2020 revealed a physician order to ensure foley bag is in privacy bag while in bed or wheelchair every shift related to [MEDICAL CONDITION], unspecified. Review of the comprehensive Care Plan dated 3/11/2020 revealed the focus area of the resident has indwelling catheter with interventions including to position the catheter bag and tubing below the level of the bladder and in a privacy bag. Check tubing for leaks and maintain the drainage bag off the floor. Observation on 3/10/2020 at 9:11 AM revealed Resident #155 was lying in bed on her left side. She had a [MEDICAL CONDITION] with [MEDICAL CONDITION]. She was not responsive to verbal stimuli although her eyes were open. She had an indwelling urinary catheter with the drainage bag attached to the lower side of the bed. The drainage bag was not in a privacy bag and the bag and the drain tube was laying on the floor. In an interview on 3/10/2020 at 9:17 AM, LVN B said the urinary drainage bag should have a privacy cover. It should not be touching the floor as that can cause infection or be stepped on or a hole put in it. In an interview on 3/12/20 at 4:01 PM, the DON said the drainage bag for the indwelling catheter should be lower than the bladder. If the tubing or drainage bag is on the floor that increases risk for infection. Review of the facility policy Catheter Care revised 2/13/07 revealed in part the following: 5. Keep tubing off floor and minimize friction or movement at insertion site. 10. Be sure the catheter tubing and drainage bag are kept off the floor.