STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675723	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Living Care Center	1475 Raynolds St El Paso, TX 79903

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 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** 46998 Based on observations, interviews, and record review the facility failed to provide treatment and care based on the comprehensive plan of care for 1 (Resident #1) of 5 residents reviewed for pressure ulcers. The facility failed to provide and assess care on 11/01/24 for Resident #1's Arterial ulcer to her right foot big toe. This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health. Findings included: Resident #1 Record review of Resident #1's face sheet dated 11/22/24, revealed, admission on 10/28/24 to the facility. Record review of Resident #1's facility history and physical dated 10/30/24, revealed, a [AGE] year-old female diagnosed with Peripheral Artery Disease, Gastric ulcer, and pain to the right foot. Record review of Resident #1's quarterly MDS dated [DATE], revealed, a moderately impaired cognition, BIMS score of 12, and was able to recall and make daily decisions. Record review of Resident #1's Orders dated 10/30/24, revealed, Arterial ulcer to big toe right foot. Cleanse with WC/NS, pat dry, apply Medi-honey, cover with ABD pad, and wrap with kerlix. Record review of Resident #1's care plan dated 11/02/24, revealed, non-pressure/surgical skin condition to right great toe with open area under the nail, with necrotic tissue. Assess the wound bed and surrounding skin for signs of infection or other complications. Record review of Resident #1's Administration Report dated 11/01/24-11/30/24, revealed, wound care was not coded and the box was blank for Resident #1 on 11/01/24 to her arterial ulcer to big toe on the right foot. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:11 PM, LVN E stated Resident #1 had a right big toe wound. LVN E stated he did not perform would care on 11/01/24 as he was the assign nurse for that shift (6AM-2PM on 11/01/24). LVN E stated the Wound Care Nurse was doing wound care. LVN E stated that wound care could be done anytime during the day and normally the wound care nurse did it, but he was able to do it if he needed too. Record review of Resident #1's grievance dated 10/30/24, revealed, Concern that Resident #1's toe was not given wound care. Resolution was changing of the charge nurse and reporting to the state. During an interview on 11/20/24 at 11:51 AM, the DON stated Resident #1 had complained that the Wound Care Nurse had not done the wound care on her toe. The DON stated her orders revealed that she was to be having wound care on Mondays, Wednesdays, and Fridays. The DON stated the toe was assessed and her wound did not get worse nor better. During an interview on 11/20/24 at 3:10 PM, ADON A stated she normally does wound care for Resident #1 but on 11/01/24 she did not as she was not working that day. ADON A stated any nurse could perform wound care in case she was out. ADON A stated she did not know who did wound care on 11/01/24 when she was out of the facility. During an interview on 11/22/24 at 9:14 AM, the SW stated a grievance was filed by Resident #1 indicating that wound care was not performed on 11/01/24. The SW stated she spoke to Resident #1 and was informed that it was resolved but she was not happy. During an interview on 11/22/24 at 11:18 AM, LVN E stated if the Wound Care Nurse was not going to be in the facility that the DON/ADONs usually let them know so that they could do the wound care. LVN E stated he usually did not do wound care, so he did not check to see if he needed to do wound care on Resident #1. LVN E stated the importance of doing wound care would be the risk of infection. During an interview on 11/22/24 at 11:47 AM, CNA G stated Resident #1 had a wound on her foot. CNA G stated Resident #1 was complaining that wound care was not done for the days she was scheduled for. CNA G stated the nurse was told of wound care for Resident #1 and the nurse did not show up to do it. During an interview on 11/22/24 at 2:17 PM, LVN D stated wound care for Resident #1 was done in the morning but could be done anytime of the day. LVN D stated upper management would let her know if she would need to do wound care. LVN D stated the orders indicated that wound care for Resident #1 was to be done in the day shift (6AM-2PM) and she was the evening shift (2PM-10PM). LVN D stated she did not do wound care on 11/01/24 as the orders stated it was to be done in the day shift (6AM-2PM). LVN D stated they would want to do wound care for Resident #1 as ordered so that her wound could heal. LVN D stated the negative outcome could be the wound worsening or getting infected. During an interview via text message with Physician C on 11/11/24/24 at 3:57 PM, Physician C stated Resident #1 had an arterial ulcer to right great toe. Physician C stated the order was to continue wound care 3 times a week. Physician C stated there was one missed wound care treatment that Resident #1 did not get. Physician C stated there was no negative outcome from the missed day. During an interview on 11/20/24 at 3:10 PM, ADON A stated any nurse could conduct wound care. ADON A stated wound care was to be done as per orders. ADON A stated the wound could worsen if not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Dressing Change: Wound policy dated 06/19, revealed, It was the policy of this facility that dressing changes will follow specific manufacture's guidelines and general infection control principles.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on the observations, interviews, and record review the facility failed to ensure that the residents environment remains free of accidents hazards as was possible and each resident received adequate supervision to prevent accidents for 1 (Resident #4) of 4 residents reviewed for accidents. The facility failed to make sure the fall mat for Resident #4 was in good condition and not torn or ripped apart. This failure could place residents at risk of falling and injuries. Findings included: Record review of Resident #4's face sheet dated 11/22/24, revealed, admission on 11/05/24 to the facility. Record review of Resident #4's facility history and physical dated 11/06/24, revealed, an [AGE] year-old female diagnosed with dementia, bipolar, and a fall. The plan was to place Resident #4 on fall precautions. Record review of Resident #4's orders dated 11/20/24, revealed, there were no orders for a fall mat. Record review of Resident #4's care plan dated 11/15/24, revealed, was at risk for falls and injuries. Encourage resident to ask for assistance of staff. Encourage resident to dangle at bedside for 1 min prior to transfer/standing. Assure lighting was adequate and areas were free of clutter. Resident #4 had impaired cognition and was at risk for further decline and injury. ADLs with transfers, was extensive assistance, from the help of one staff and depended on one staff for walking. Observation and interview on 11/20/24 at 9:53 AM, with ADON A. It was observed Resident #4 to be lying down in bed covered up on her right side. Resident #4 had a blue fall mat placed on her side of the bed. The blue mat was torn straight down the middle of the foldable part. Exposing the yellow foam, white and blue strings, and pieces of the blue material were torn. ADON A stated she had not noticed the fall mat being torn like it was. ADON A stated it was inappropriate being torn and did not look right. ADON A stated there could be a risk if the fall mat was torn such as a fall. ADON A stated it was the responsibility of whoever sees the fall mat torn to report and replace it. During an interview on 11/20/24 at 10:20 AM, LVN E stated he did not know the fall mat was torn. LVN E stated when Resident #4 entered the facility two weeks ago that one of the facilities ADONs had placed that blue mat. LVN E stated it was ADON F who was working that night. LVN E stated the fall mat being torn was not right. LVN E stated the nurses were responsible for replacing the torn fall mat. LVN E stated if someone or Resident #4 were to step on the torn fall mat it could possibly go one way while the other piece goes the other way. LVN E stated it was a risk for Resident #4 who was a fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 11:51 AM, the DON stated torn or ripped fall mats were to be reported to maintenance. The DON stated the risk could be another fall or someone being injured. In an interview on 11/20/24 at 2:39 PM, the Maintenance Director stated the DOR took care of broken and damaged equipment and that was not his department. In an interview on 11/20/24 at 2:54 PM, the DOR stated that his department received reports of damaged therapy devices such as wheelchairs, walkers, and canes, which they fix or replace. The DOR stated if they could not fix something right away then they let maintenance know. The DOR stated the fall mat would be more of an intervention coming from nursing. The DOR stated there would be a risk if the fall mat was compromised and the resident was a fall risk which would be more of a risk. The DOR stated Resident #4 was a fall risk and the negative outcome could be a fall. The DOR stated the blue fall mat being torn was compromised and needed to be replaced. In an interview on 11/22/24 at 11:04 AM, the DON stated the facility did not have any policy regarding accidents/hazards. During an interview on 11/22/24 at 2:28 PM, LVN D stated Resident #4 was a fall risk and part of her interventions were to place her near the nurse's station, have her bed low, and a fall mat placed. LVN D stated she did not see Resident #4's fall mat being torn the way it was. LVN D stated she would have changed it right away. LVN D stated the risk was the resident or anybody stepping on the fall mat and it moving.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 (Resident #5) of 4 residents observed for oxygen management. Resident #5 was being given oxygen without physician orders from 10/20/24-10/25/24. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. Findings included: Record review of Resident #5's face sheet dated 11/20/24, revealed, admission on 10/04/24 to the facility. Record review of Resident #5's facility history and physical dated 10/07/24, revealed, a [AGE] year-old female not diagnosed with anything at the time that would warrant oxygen use. Indicated Resident #5 denied any SOB or wheezing. The plan was to monitor oxygen and maintain adequate oxygen saturation. Keep saturation above 90 percent. Record review of Resident #5's admission MDS dated [DATE], revealed, a severely impaired cognition, BIMS score of 05, she was to be able to recall and make daily decisions. Was not coded for oxygen therapy use. Record review of Resident #5's orders dated 11/20/24, revealed, there were no orders for oxygen. Record review of Resident #5's care plan dated 11/20/24, revealed, there was no mention of oxygen therapy use for Resident #5. Resident was not at the facility at the time of investigation. During an observation and interview on 11/22/24 at 3:04 PM, CNA E stated Resident #5 was on oxygen and observed Resident #5 with a nasal cannula on which was positioned correctly on her face. During an interview on 11/20/24 at 3:29 PM, ADON A stated Resident #5 had acquired Covid-19 from a visit from a family member. ADON A stated Resident #5 had tested positive for Covid and was getting breathing treatments. ADON A stated Resident #5 had orders for oxygen. During an interview on 11/22/24 at 9:14 AM, the SW stated Resident #5 had pneumonia when she came into the facility but later acquired Covid from a family member who came to visit her. The SW stated Resident #5 was wheezing from her lungs and an x-ray was taken. The SW stated there were orders given for Resident #5 to start nebulizer treatments. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 11:09 AM, the DON stated for any medications the facility would need an order for them. The DON stated oxygen was a medication. The DON stated you would need an order for oxygen use. The DON stated Resident #5 did not have orders for oxygen. The DON stated Resident #5 did enter the facility with oxygen from the hospital. The DON stated she reviewed the vitals for oxygen revealing Resident #5 was on oxygen at 4 liters per minute via nasal cannula. The DON did not indicate what the risk would be if there were no orders for oxygen and it was being given. The DON stated the nurses were responsible for ensuring the orders were in the system. During an interview via text message sent by Physician C on 11/24/24 at 3:57 PM, stated, if a resident was going to continue to be on oxygen, then the facility would have had to have gotten an order for the oxygen use. During an interview on 11/22/24 at 2:28 PM, LVN D stated when she started working at the facility, she did not remember seeing Resident #5 having a nasal cannula on or using oxygen. LVN D stated Resident #5 did have a concentrator in her room. LVN D stated you would need a physician order for the use of oxygen. LVN D stated you would need to notify the physician because you would want the resident to be above 90 percent saturation. LVN D stated the negative outcome would be the resident not getting the proper oxygen which could lead to something else going on. Record review of the facility Physician Orders policy dated 06/19, revealed, Policy: It was policy of this facility that qualified licensed nurses will obtain and transcribe orders according to Facility Practice Guidelines. Record review of the facility Oxygen Therapy: General Administration & Care policy dated 08/19, revealed, Policy: It was the policy of this facility that the facility will provide oxygen therapy by means of various administration devices. Review physician's order on the chart for completeness. Document initiation of therapy in the medical record, per documentation standards.