

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society--White Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 7304 Good Samaritan CT El Paso, TX 79912	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #7) of 9 residents reviewed for dignity.</p> <p>Resident #7's catheter bag did not have a privacy bag cover exposing the catheter bag.</p> <p>This failure could place residents at risk of diminished quality of life and compromise residents' dignity for those who require a urinary catheter care.</p> <p>Findings included:</p> <p>Record review of Resident #7's face sheet dated 03/06/24, revealed, admission on 10/18/21 to the facility.</p> <p>Record review of Resident #7's hospital history and physical dated 12/08/23, revealed, a [AGE] year-old male diagnosed with Neurogenic Bladder (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem) and Long-Term Foley Catheter (catheterization for one month or longer).</p> <p>Record review of Resident #7's quarterly MDS dated [DATE], revealed, an intact cognition to be able to recall and make daily decisions BIMS (a quick snapshot of how well you are functioning cognitively at the moment) score of 15. Resident #7 has an indwelling catheter.</p> <p>Record review of Resident #7's care plan dated 08/15/23, revealed, a suprapubic catheter due to obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow. Document intake and output. Monitor/record/report to health care provider. Catheter care by CNA every shift.</p> <p>Observation on 03/05/24 at 4:17 PM, revealed, Resident #7 was lying down in bed with his catheter bag hanging from the left side of the bed. The catheter bag was filled up to 400 mls (milliliters) of dark yellow urine. The catheter bag was not covered in a privacy bag exposing the catheter bag. Resident #7's room door was open and the catheter bag could be seen from the hallway.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 03/05/26 at 4:29 PM, with LVN A, he looked into Resident #7's room from the hall and stated Resident #7 had no privacy on his catheter bag. LVN A stated it was expected that nursing staff put on a privacy bag on the catheter bags. LVN A stated not having the privacy bag could be a risk of embarrassment, infection, and urinary tract infections for Resident #7.</p> <p>During an interview on 03/07/24 at 3:40 PM, with the Nurse Manager, she stated Resident #7's catheter bag need to be place into a privacy blue bag. The Nurse Manager stated it was for Resident #7 rights and infection control. The Nurse Manager stated it was both the nurses and CNAs responsibility to ensure they blue privacy bags are on the catheter bags.</p> <p>During an interview on 03/08/24 at 2:06 PM, with the DON, stated the catheter bags need to have a privacy cover, the blue bags. DON stated it was for privacy of the resident since it containers urine in which the resident might get embarrassed and also be an infection issue.</p> <p>During an interview on 03/14/24 at 2:40 PM, with CNA B, she stated residents with catheter bags need to have a privacy bag cover on. CNA B stated there could be a negative outcome for the resident. CNA B stated if it was the residents first time having the catheter bag then they might get embarrassed about it.</p> <p>Record review of facility Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen-Assisted Living, Rehab/skilled policy dated 02/10/23, revealed, Catheter tubing/drainage bags - Every effort was made to keep a resident's catheter covered or out sight. Catheter bags should be covered when up in a chair and out in public or visible from door/hall.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interviews and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #4) of 3 residents reviewed for wanting her room light on at all times in that:</p> <p>The facility failed to ensure that Residents #4 room lights remained on at all times as requested by Resident #4.</p> <p>This failure put residents at risk of their preferneces not being honored.</p> <p>Findings included:</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 03/06/24, revealed, admission on 12/10/1 and re-admission on 07/20/20 to the facility.</p> <p>Record review of Resident #4's hospital history and physical dated 03/03/23, revealed, a [AGE] year-old female diagnosed with Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), anxiety disorder (persistent and excessive worry that interferes with daily activities), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve), artificial hip joint (a surgeon removes the damaged sections of the hip joint and replaces them with parts usually constructed of metal, ceramic and very hard plastic), and joint replacement surgery (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part).</p> <p>Record review of Resident #4's quarterly MDS dated [DATE], revealed a severe cognition to be able to recall and make daily decisions BIMS (a quick snapshot of how well you are functioning cognitively at the moment) score of 6. Resident #4 was marked zero (Adequate) for vision for ability to see in adequate light. Resident #4 does not use corrective lenses. Active diagnoses was Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve).</p> <p>Record review of Resident #4's care plan dated 03/06/24, revealed, there was no focus area for resident preference of having the room light on at all times.</p> <p>During an interview on 03/05/24 at 3:12 PM, with the family member, she stated there was an order for Resident #4 to have her room light on due to her having a diagnosis of glaucoma. The family member stated the DON would go into her room and turn it off after knowing this. The family member stated Resident #4 needed her room light on at all times and had already told facility staff to keep on.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/14/24 at 4:16 PM, with the MA, she stated Resident #4 preferred to have her room light on at all times as well as other facility staff. The MA stated the DON would turn it off and Resident #4 would ask her to turn I back on. The MA stated the DON knew Resident #4 liked having the room light on because he worked the night shift. The MA stated she did not know if it had to be care planned and did not indicate if there would be a risk not being care planned as it was out of her area.</p> <p>During an interview on 03/15/24 at 8:28 AM, with LVN D, she stated Resident #4 requested to have the room light on all the time. LVN D stated she did not see the room lights being on at all times care plan or a physician order for it for Resident #4. LVN D stated it should have been care planned and not having it care planned for Resident #4 could be a risk to her preferences and rights.</p> <p>During an interview on 03/15/24 at 9:20 AM, with LVN C, she stated Resident #4 preferred to have the room light on and demand it stayed on. LVN C stated she recalled the DON turning off Resident #6's room light off but did not remember the day. LVN C stated the DON did work night shift sometimes. LVN C stated everyone knew Resident #6 always wanted her room light on at all times. LVN C stated it should have been care planned because it would have been considered a behavior, it was her right, it was her preference, and she had roommates on and off. LVN C stated there was no negative outcome with not having it care planned because she would not turn off the lights so she would not know who she would get if she were to turn of the room lights. LVN C said if I were to say I wanted the room lights to be on at all times and it was turned off she would be angry for not respecting her.</p> <p>During an interview on 03/15/24 at 9:40 AM, with MDS Coordinator, she stated that she did not recall Resident #4 voicing out that she wanted the room lights on at all times in the morning meeting or care plan meeting. MDS Coordinator stated if Resident #4 wanted to have the room lights on at all times it would have had to be care planned. MDS Coordinator stated it would be placed on residents' preferences because it would be her right to have it on or off. MDS Coordinator stated there would be a risk of not care planning it in which the facility staff might turn off the light and also violating her rights.</p> <p>During an interview on 03/15/24 at 10:17 AM, DON, he stated he believed Resident #4's over head bed light was on at all times. The DON stated he did not turn off the overhead bed light. The DON stated Resident #4 also had the cord to the overhead light and would be able to turn it on or off. The DON stated he could not say for sure if it needed to be care plan as it was not his area but would say yes to it being care planned. The DON stated it was her preference and her right to have the room light on at all times.</p> <p>Record review of the facility Resident Rights - Nursing Facilities poster dated 04/2019, revealed, Resident of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.</p> <p>Dignity and Respect - You have the right to: Live in safe, decent and clean conditions.</p> <p>Be treated with dignity, courtesy, consideration and respect.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility Resident's Rights for Skilled Nursing Facilities booklet dated 10/04/16, revealed, Resident's Rights - (a) The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:</p> <p>(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>(b) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. - (1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.</p> <p>(e) The resident has a right to be treated with dignity.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on interviews and record reviews the facility failed to coordinate assessments in which a PE was not conducted after the pre-admission screening indicating a Yes for intellectual disability and resident review (PASARR) program under Medicaid for 1 (Resident #6) of 2 residents reviewed for PASRR Evaluation.</p> <p>The failed to conduct a PASRR Evaluation for Resident #6 after coming out positive on the PASRR Level 1.</p> <p>This failure can place residents who are PASRR positive at risk of not getting the PASARR services for a better quality of life and could lead to a decline in health.</p> <p>Findings include:</p> <p>Record review of Resident #6's face sheet dated 03/06/24, revealed admission on 08/17/23 to the facility.</p> <p>Record review of Resident #6's PASRR Level 1 Screening conducted by RN Case Manager dated 08/11/23, revealed, Resident #6 was positive for intellectual disability.</p> <p>Record review of Resident #6's PASRR Level 1 Screening conducted by Admission Coordinator dated 08/17/23, revealed, Resident #6 was positive for intellectual disability and developmental disability.</p> <p>Record review of Resident #6's Physical Therapy Plan of Care dated 08/18/23, revealed, an [AGE] year old female diagnosed with Mental Retardation (significantly subaverage intellectual functioning), osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes), and right hip open reduction and internal fixation (surgery used to stabilize and heal a broken bone) to tibia/fibula, head of hearing.</p> <p>Record review of Resident #6's PASRR Comprehensive Services Plan Form dated 09/13/23, revealed, Resident #6 was positive for PASRR.</p> <p>Record review of Resident #6's progress notes generated by the Social Worker dated 09/13/23, revealed, the care conference with for Resident #6 was held to discuss PASRR with the local mental health authority and facility staff (the interdisciplinary team).</p> <p>Record review of Resident #6 dated 03/06/24, revealed there was no PASRR Evaluation conducted for Resident #6 after determining on the PASRR Level 1 Screening that Resident #6 was positive for PASRR.</p> <p>Record review of Resident #6's baseline care plan dated 03/06/24, revealed, there was not care plan for PASRR services.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/08/24 at 3:36 PM, with the MDS Coordinator, she stated she does not handle and does not know much about PASRR services. MDS Coordinator stated the Director of Rehab and the Social Worker handle PASRR Services. MDS Coordinator stated a meeting was held with the local mental health authority. MDS Coordinator stated Resident #6 was receiving PASRR services out in the community according to her understanding. MDS Coordinator stated she did not know if a PASRR Evaluation was done or if the request for PASRR Services was submitted to state agency.</p> <p>During an interview on 03/14/24 at 9:15 AM, with the Social Worker, she stated Resident #6's meeting was held with the local health authority. The Social Worker stated Resident #6 was PASRR positive and the meeting was held on 09/13/24. The Social Worker stated the PASRR Evaluation was not done due to Resident #6 receiving PASRR services out in the community. The Social Worker stated that the request for PASRR services was not submitted to state agency after the meeting was held be due to the local mental health authority telling the facility that Resident #6 was already receiving PASRR services out in the community. The Social Worker stated Resident #6 was receiving skilled physical therapy and occupational therapy from the facility. The Social Worker stated there was not risk to Resident #6 because she was already receiving PT and OT services form the facility.</p> <p>During an interview on 03/15/24 at 10:05 AM, with the Director of Rehab, he stated there was no PASRR Evaluation done, and the therapy department was going to pick up Resident #6 but was getting ready to be discharged from the facility. The Director of Rehab stated a meeting was held with the local mental health authority regarding Resident #6 PASRR services. The Director of Rehab stated after the meeting submission to the state agency was not conducted since Resident #6 was going to leave the facility. The Director of Rehab stated Resident #6 was receiving therapy services form the facility so there was no risk to Resident #6 for no doing a PASRR evaluation and submitting the request for PASRR Services to state agency.</p> <p>During an interview on 03/15/24 at 10:39 AM, with Local Mental Health Authority E and Local Mental Health Authority F. Local Mental Health Authority E stated that Resident #6 was not receiving PASRR Services out in the community and they do not follow the resident out in the community. The Local Mental Health Authority F stated Resident #6 did require PASRR Services and should have been receiving them. The Local Mental Health Authority E stated the facility did not conduct a PASRR Evaluation nor did they submit approval for PASRR Services request to the state agency. Local Mental Health Authority F stated there could have been a risk to Resident #6 of not receiving PASRR Services with her declining.</p> <p>Record review of the facility Pre-Admission Screening and Resident Review Rehab/Skilled policy dated 12/11/23, revealed, Purpose - To determine admission criteria for residents with mental illness and or mental retardation. To ensure that individuals with retardation, serious mental disorder or intellectual disability receive the care and services they need in the most appropriate setting.</p> <p>The PASRR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening was referred to as a Level 1 and was completed prior to admission to a nursing facility. The purpose of the Level 1 pre-admission screening was to identify individuals who have or may have MD/ID or a related condition, who would then require PASRR Level 2 Evaluation.</p> <p>(continued on next page)</p>		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Level 2 PASRR screening was conducted by the agency designed by the state. This screening will determine whether the prospective resident requires the level of services provided by the location and whether the individual requires specialized services.

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 2 (Resident #4 and Resident #6) of 9 residents reviewed for care plans in that:</p> <p>The facility failed to implement a comprehensive person-centered care plan for Resident #4's history of wanting her room light on all the time.</p> <p>The facility failed to implement a comprehensive person-centered care plan for Resident #6's PASRR positive for services.</p> <p>This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.</p> <p>Findings include:</p> <p>Resident #4</p> <p>Record review of Resident #4's face sheet dated 03/06/24, revealed, admission on 12/10/1 and re-admission on 07/20/20 to the facility.</p> <p>Record review of Resident #4's hospital history and physical dated 03/03/23, revealed, a [AGE] year-old female diagnosed with Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), anxiety disorder (persistent and excessive worry that interferes with daily activities), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve), artificial hip joint (a surgeon removes the damaged sections of the hip joint and replaces them with parts usually constructed of metal, ceramic and very hard plastic), and joint replacement surgery (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part).</p> <p>Record review of Resident #4's quarterly MDS dated [DATE], revealed a severe cognition to be able to recall and make daily decisions BIMS (a quick snapshot of how well you are functioning cognitively at the moment) score of 6. Resident #4 was marked zero (Adequate) for vision for ability to see in adequate light. Resident #4 does not use corrective lenses. Active diagnoses was Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve).</p> <p>Record review of Resident #4's care plan dated 03/06/24, revealed, there was no focus area for resident preference of having the room light on at all times.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/05/24 at 3:12 PM, with the family member, she stated there was an order for Resident #4 to have her room light on due to her having a diagnosis of glaucoma. The family member stated the DON would go into her room and turn it off after knowing this. The family member stated Resident #4 needed her room light on at all times and had already told facility staff to keep on.</p> <p>During an interview on 03/14/24 at 4:16 PM, with the MA, she stated Resident #4 preferred to have her room light on at all times as well as other facility staff. The MA stated the DON would turn it off and Resident #4 would ask her to turn I back on. The MA stated the DON knew Resident #4 liked having the room light on because he worked the night shift. The MA stated she did not know if it had to be care planned and did not indicate if there would be a risk not being care planned as it was out of her area.</p> <p>During an interview on 03/15/24 at 8:28 AM, with LVN D, she stated Resident #4 requested to have the room light on all the time. LVN D stated she did not see the room lights being on at all times care plan or a physician order for it for Resident #4. LVN D stated it should have been care planned and not having it care planned for Resident #4 could be a risk to her preferences and rights.</p> <p>During an interview on 03/15/24 at 9:20 AM, with LVN C, she stated Resident #4 preferred to have the room light on and demand it stayed on. LVN C stated she recalled the DON turning off Resident #6's room light off but did not remember the day. LVN C stated the DON did work night shift sometimes. LVN C stated everyone knew Resident #6 always wanted her room light on at all times. LVN C stated it should have been care planned because it would have been considered a behavior, it was her right, it was her preference, and she had roommates on and off. LVN C stated there was no negative outcome with not having it care planned because she would not turn off the lights so she would not know who she would get if she were to turn of the room lights. LVN C said if I were to say I wanted the room lights to be on at all times and it was turned off she would be angry for not respecting her.</p> <p>During an interview on 03/15/24 at 9:40 AM, with MDS Coordinator, she stated that she did not recall Resident #4 voicing out that she wanted the room lights on at all times in the morning meeting or care plan meeting. MDS Coordinator stated if Resident #4 wanted to have the room lights on at all times it would have had to be care planned. MDS Coordinator stated it would be placed on residents' preferences because it would be her right to have it on or off. MDS Coordinator stated there would be a risk of not care planning it in which the facility staff might turn off the light and also violating her rights.</p> <p>During an interview on 03/15/24 at 10:17 AM, DON, he stated he believed Resident #4's over head bed light was on at all times. The DON stated he did not turn off the overhead bed light. The DON stated Resident #4 also had the cord to the overhead light and would be able to turn it on or off. The DON stated he could not say for sure if it needed to be care plan as it was not his area but would say yes to it being care planned. The DON stated it was her preference and her right to have the room light on at all times.</p> <p>Resident #6</p> <p>Record review of Resident #6's face sheet dated 03/06/24, revealed admission on 08/17/23 to the facility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Good Samaritan Society--White Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 7304 Good Samaritan CT El Paso, TX 79912	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #6's Physical Therapy Plan of Care dated 08/18/23, revealed, an [AGE] year old female diagnosed with Mental Retardation (significantly subaverage intellectual functioning), osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes), and right hip open reduction and internal fixation (surgery used to stabilize and heal a broken bone) to tibia/fibula, head of hearing.</p> <p>Record review of Resident #6's PASRR Level 1 Screening conducted by RN Case Manager dated 08/11/23, revealed, Resident #6 was positive for intellectual disability.</p> <p>Record review of Resident #6's PASRR Level 1 Screening conducted by Admission Coordinator dated 08/17/23, revealed, Resident #6 was positive for intellectual disability and developmental disability.</p> <p>Record review of Resident #6 dated 03/06/24, revealed there was no PASRR Evaluation conducted for Resident #6 after determining on the PASRR Level 1 Screening that Resident #6 was positive for PASRR.</p> <p>Record review of Resident #6's PASRR Comprehensive Services Plan Form dated 09/13/23, revealed, Resident #6 was positive for PASRR.</p> <p>Record review of Resident #6's progress notes generated by the Social Worker dated 09/13/23, revealed, the care conference with for Resident #6 was held to discuss PASRR with the local mental health authority and facility staff (the interdisciplinary team).</p> <p>Record review of Resident #6's baseline care plan dated 03/06/24, revealed, there was not care plan for PASRR services.</p> <p>During an interview on 03/14/24 at 2:18 PM, with MDS Coordinator, she stated that was Resident #6 was admitted to the facility on [DATE] and on 09/13/23, the facility held the care plan meeting with the local health authority revealing that Resident #6 required PASRR services. MDS Coordinator stated once the meeting was held with the local health authority for the PASRR services required for Resident #6, should have been care plan and were not care planed. MDS Coordinator stated PASRR Services for any PASRR positive resident would have had to be implemented in their care plan. MDS Coordinator stated she did not receive the PASRR Level 1 Screening on 08/11/23, that lets her know Resident #6 was PASRR positive. MDS Coordinator stated it was the responsibility of Admissions Coordinator, Social Worker, and MDS Coordinator to ensure she received the documentation for the PASRR positive resident. MDS Coordinator stated the risk to Resident #6 would be not getting the PASRR Services. MDS Coordinator stated the purpose of a care plan was to meet the needs of the resident with interventions on how to provide those services.</p> <p>Record review of the facility Comprehensive Care policy dated 12/04/23, revealed, Purpose - to develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial well-being.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Care Plan - the resident care plan in the facility system includes the tab titled care plan, but was not limited to this tab. This may include other areas in the facility system such as: Orders, assessments and tasks tabs, in plan of care and medical administration record/treatment administration record that are used to plan and communicate services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan may also include services not provided due to the residents right to refuse treatment.</p> <p>Person-centered care - to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.</p> <p>Record review of the facility Pre-Admission Screening and Resident Review Rehab/Skilled policy dated 12/11/23, revealed, Purpose - To determine admission criteria for residents with mental illness and or mental retardation. To ensure that individuals with retardation, serious mental disorder or intellectual disability receive the care and services they need in the most appropriate setting.</p> <p>During the Stay - [NAME] recommendations will be incorporated into the care plan.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 (Resident #2 and Resident #7) of 3 residents observed for oxygen management.</p> <p>Resident #2's nasal cannula was not bag while it was not in use.</p> <p>Resident #7's catheter bag did not have a privacy bag cover exposing the catheter bag which could cause infection.</p> <p>This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 03/06/24, revealed, admission on 10/25/22 to the facility.</p> <p>Record review of Resident #2's facility history and physical dated 10/04/23, revealed, a [AGE] year-old female diagnosed with Chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), and history of Covid-19 (an infectious disease caused by the SARS-CoV-2 virus),.</p> <p>Record review of Resident #2's annual MDS dated [DATE], revealed, a moderate cognition to be able recall and make daily decision BIMS (a quick snapshot of how well you are functioning cognitively at the moment) score of 12. Resident #2 was on oxygen therapy. diagnosed with Chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #2's orders dated 05/29/23, revealed, oxygen at 2 liter per minute per nasal cannula via oxygen concentrator and or tank while in bed every shift related to chronic obstructive pulmonary disease.</p> <p>Record review of Resident #2's care plan dated 05/04/23, revealed, oxygen therapy due to ineffective gas exchange. Monitor for sign and symptoms of respiratory distress and report to health care provider as needed. Respiration, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion.</p> <p>Observation on 03/06/24 at 10:32 AM, revealed, Resident #2 was on her wheelchair near the front lobby area. Nasal cannula was placed on the right rear handled and was hanging off to the right side. Oxygen tank was full and nasal cannula unbagged. Resident #2 was not in respiratory distress, resident was not wheezing, o struggling to breath.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/06/24 at 1:20 Pm, revealed, Resident #2 was in the front lobby area in her wheelchair. Resident #2's nasal cannula was placed on the oxygen tank behind her wheelchair unbagged.</p> <p>Observation and interview on 03/07/24 at 3:40 PM, The Nurse Manager observed Resident #2's nasal cannula not in use hanging of the back side of her wheelchair. The Nurse Manager stated the nasal cannula was to be placed in a plastic bag. The Nurse Manager stated it was everyone's responsibility to place the nasal cannula in the plastic bag when not in use.</p> <p>During an interview on 03/08/24 at 2:06 PM, with the DON, he stated residents with nasal cannula that were not in use had to be placed in a zip lock bag. The DON stated it was a risk of infection. The DON stated it was everyone's responsibility for ensuring the nasal cannulas were in a zip lock bag when not in use.</p> <p>Resident #7</p> <p>Record review of Resident #7's face sheet dated 03/06/24, revealed, admission on 10/18/21 to the facility.</p> <p>Record review of Resident #7's hospital history and physical dated 12/08/23, revealed, a [AGE] year-old male diagnosed with Neurogenic Bladder (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem) and Long-Term Foley Catheter (catheterization for one month or longer).</p> <p>Record review of Resident #7's quarterly MDS dated [DATE], revealed, an intact cognition to be able to recall and make daily decisions BIMS (a quick snapshot of how well you are functioning cognitively at the moment) score of 15. Resident #7 has an indwelling catheter.</p> <p>Record review of Resident #7's care plan dated 08/15/23, revealed, a suprapubic catheter due to obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow. Document intake and or output. Monitor/record/report to health care provider. Catheter care by CNA every shift.</p> <p>Observation on 03/05/24 at 4:17 PM, revealed, Resident #7 was lying down in bed with his catheter bag hanging from the left side of the bed. The catheter bag was filled up to 400 mls (milliliters) of dark yellow urine. The catheter bag was not covered in a privacy bag exposing the catheter bag. Resident #7's room door was open and the catheter bag could be seen from the hallway.</p> <p>Observation and interview on 03/05/26 at 4:29 PM, with LVN A, he looked into Resident #7's room from the hall and stated Resident #7 had no privacy on his catheter bag. LVN A stated it was expected that nursing staff put on a privacy bag on the catheter bags. LVN A stated not having the privacy bag could be a risk of infection and or urinary tract infections for Resident #7.</p> <p>During an interview on 03/07/24 at 3:40 PM, with the Nurse Manager, stated Resident #7's catheter bag needed to be place into a privacy blue bag. Nurse Manager stated it was for Resident #7 rights and infection control. The Nurse Manager stated it was both the nurses and CNAs responsibility to ensure they blue privacy bags are on the catheter bags.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/08/24 at 2:06 PM, with the DON stated the catheter bags need to have a privacy cover, the blue bags. The DON stated the risk could be infection issue.</p> <p>During an interview on 03/14/24 at 2:40 PM, with CNA B, she stated residents with catheter bags are to have privacy covers on for sanitation and bacterial purposes.</p> <p>Record review of facility Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen-Assisted Living, Rehab/skilled policy dated 02/10/23, revealed, Catheter tubing/drainage bags - Every effort was made to keep a resident's catheter covered or out sight. Catheter bags should be covered when up in a chair and out in public or visible from door/hall.</p> <p>Record review of the facility Infection Prevention and Control Programs, All service Lines dated 10/30/23, revealed, Purpose - to establish and 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 infection.</p>