STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675025	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society--White Acres	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review the facility failed to ensure a resident, who was fed by enteral means, received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 7 residents (Resident #7) reviewed for enteral feeding. The facility failed to ensure Resident #7's head of bed was maintained at 30 degrees elevated while receiving continuous feeding. The failure could place residents at risk of aspiration (when food or liquid goes into the lungs or airway). Findings included: Record review of Resident #7's face sheet dated 09/27/24 revealed a [AGE] year old male who was admitted to the facility on [DATE] with diagnoses of anoxic brain damage (brain damage from a lack of oxygen to the brain), persistent vegetative state (condition in which a person is awake but has no awareness of their surroundings or themselves), Parkinson's disease (movement disorder of the nervous system that worsens over time), and contracture (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement). Record review of Resident #7's annual MDS assessment dated [DATE] revealed he was severely cognitive impaired, was dependent with bed mobility and had enteral feeding (intake of food via the gastrointestinal tract). Record review of Resident #7's care plan dated 01/28/24 revealed a focus area for requires tube feeding related to Dysphagia (difficulty swallowing) with a goal of will remain free of side effects or complications related to tube feeding through review date and interventions that included Elevate HOB (head of bed) i.e. 30-45 degrees during and i.e. 30-40 minutes after tube feeding is stopped. During an observation on 09/27/24 at 8:57 am, revealed Resident #7 was in bed with the continuous enteral feeding running at 65ml/hr. Resident #7's bed was elevated at approximately 30 degrees while Resident #7's head and torso were not elevated at 30 degrees and he was lying flat on his back. No signs of distress were noted. (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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/27/24 at 09/27/24 at 9:00 am, revealed LVN A was in Resident #7's room at his bedside and stated his head of bed was elevated at 30 degrees but Resident #7 was not as he was lying on his back. LVN A stated CNAs and nurses were responsible of ensuring residents who received continuous enteral feeding like Resident #7 were repositioned with the head of bed elevated at least 30 degrees. LVN A stated CNAs and nurses conducted rounds at least every 2 hours to ensure proper positioning for residents on continuous enteral feeding. LVN A stated she had received training on proper positioning for residents who were on continuous feeding at least monthly. LVN A stated failure to positioned Resident #7 head of bed at 30 degrees placed him at risk of aspiration (occurs when contents such as food, drink, saliva, or vomit enters the lungs). During an interview on 09/27/24 at 9:06 am, CNA B stated she was the responsible for Resident #7 and had last seen him approximately 10 minutes ago and he had been re-positioned with his upper body at approximately 30 degrees. CNA B stated CNAs and nurses were responsible of ensuring residents on enteral feeding were positioned at 30 degrees by doing their rounds at least every 2 hours. CNA B stated she had received training on proper care for residents on enteral feeding at least monthly and included proper positioning at 30 degrees. CNA B stated risk included aspiration. During an interview on 09/27/24 at 11:43 am, the DON stated all CNAs and nurses were responsible for ensuring resident who received continuous feeding were positioned with the head of bed elevated at least 30 degrees. The DON stated CNAs and nurses received training on proper care for residents on continuous feeding upon hire, annually and monthly. The DON stated the charge nurses were responsible for ensuring proper position during their continuous rounds. The DON stated risk included reflux that could result in aspiration. Record review of Tube (enteral) Feeding General Information policy dated 02/02/24 reflected in part Suggested protocol for enteral tube feeding orders: elevated head of bed 30-45 degrees at all times during feeding.

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43871 Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 6 residents (Resident #2) reviewed for accuracy of clinical records. The facility failed to ensure Resident 2's treatment administration record accurately documented treatment for orders before 09/13/24, for the Resident #2's wander guard. This failure could place residents at risk of inaccurate medical records that could affect monitoring and medical services provided. Findings include: Record review of Resident #2's face sheet dated 09/25/24, revealed admission on 08/07/23 and re-admission on 09/13/24 to the facility . Record review of Resident #2's hospital history and physical dated 05/20/24, revealed a history of falls, failure to thrive, Type 2 Diabetes, muscle weakness, abnormalities of gait and mobility, lack of coordination, and Dementia. Record review of Resident #2's order recap dated 05/08/24 revealed a start date from 05/08/24-09/13/24 and was discontinued for, Wander Guard to back of wheelchair. Monitor closely due to elopement risk. Every shift for elopement risk. On hold from 05/16/24-05/18/24, on hold from 08/10/24-08/13/24, and on hold from 09/08/24-09/15/24. Record review of Resident #2 care plan dated 03/24, revealed, the resident had a behavior symptom related to Post-Traumatic Stress Disorder, anxiety, dementia, and was an elopement risk. Minimize potential of resident behavior problems by modifying environmental factors and daily routine by providing re-orientation, communicating with Primary Care Physician - using wander guard. Record review of Resident #2's Physical Device and or Restraint Evaluation and Review dated 05/03/24, revealed, other device was coded - Specify other device: Wander Guard. How will this device benefit and or allow the resident to reach their highest level of independence? Wander guard in place due to wandering and voicing wanting to leave. Record review of Resident #2's Physical Device and or Restraint Evaluation and Review dated 07/31/24, revealed, other device was coded - Specify other device: Wander Guard. How will this device benefit and or allow the resident to reach their highest level of independence? To keep resident safe and alert staff when he wants to go outside. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/24 at 3:34 PM, the DON stated Resident #2 had a wander guard device on his wheelchair. The DON stated anybody wearing a wander guard needed to have a physician's order. The DON stated there was no physician's order found for a wander guard order before 09/13/24 for Resident #2. The DON stated the facility was providing a service without a physician's order for Resident #2 having a wander guard on. During an interview on 09/26/24 at 3:05 PM, the DON stated Resident #2 no longer had the wander guard placed after coming back from the hospital in September 2024. During an interview via text message on 09/27/24 at 8:42 AM, the Physician stated it was required by the CMS to have an order for a resident using a wander guard. The Physician stated the facility could have standing orders to use for patients who have been diagnosed with Dementia or cognitive impairment who facility staff are concerned about them wandering to unsafe areas. During an observation and interview on 9/27/24 at 8:49 am, Resident #2 was alert and oriented to person and event stated he could not remember when he had tried leaving, where he was going or time of day he left. Resident #2 did not have a wander guard noted on him. Record review of the facility Nursing Documentation Guidelines policy dated 05/06/24, revealed, The Purpose was to ensure appropriate documentation was completed in a timely manner. Record review of the facility Documentation: Nursing Related Assessments, Focus Audit policy dated 05/06/24, revealed, policy did not relate to accuracy of documentation. No other policy was brought forth prior to exit. Record review of the facility Admission Documentation dated 05/02/24, revealed, policy did not relate to accuracy of documentation. No other policy was brought forth prior to exit. Record review of the facility Physician/Practitioner Order dated 04/01/24, revealed, The purpose was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders .