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	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Acres Wellness & Rehabilitation	7304 Good Samaritan Court 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a comprehensive person-centered care plan were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment for 1 of 6 residents (Resident #6) reviewed for care plans.The facility failed to invite hospice as part of the IDT team to help develop and implement a comprehensive person-centered care plan for Resident #6 who was on hospice.Findings include:Record review of Resident #6's face sheet dated 08/07/25, revealed, admission on [DATE] to the facility. Record review of Resident #6's hospital history and physical dated 03/31/25, revealed, a [AGE] year-old male diagnosed with Diabetes Mellitus and on hospice.Record review of Resident #6's quarterly MDS dated [DATE], revealed, a moderately impairment cognition BIMS of 12 to be able to recall or make daily decisions. Section O (Special Treatments, Procedures, and Programs) - was coded K1. Hospice Care. Record review of Resident #6's care plan dated 04/03/25, revealed, Resident #6 had a terminal prognosis and had elected to participate in hospice services. Consult with physicians and social services to have hospice care for resident in the facility.During an interview on 08/06/25 at 10:19 AM, with the family member, she stated the Hospice Team confirmed that the facility had not reached out to have the Hospice Team to be part of Resident #6's IDT team during his care plan meetings. The family member stated Hospice was finally invited for a care plan meeting that would be taking place sometime in September 2025, many months later after his admission [DATE]). During an interview on 08/06/25 at 10:22 AM, with the Ombudsman, he stated he was notified that by the family member Resident #6 had not had hospice be part of his care plan meeting(s). Ombudsman stated he was still looking into that situation to see what was going on.During an interview on 08/06/25 at 2:44 PM, with the Hospice Administrator, she stated hospice had to routinely ask the facility for information about Resident #6 so they could supply the facility with their hospice care plan for Resident #6 as they were not invited to the care plan meetings.During an interview on 08/06/25 at 4:37 PM, with Hospice Physician, he stated that it was very important that Hospice be at the care plan meetings as it was in the best interest for Resident #6 and the services that would be provided for care for him. The Hospice Physician stated that hospice always asks to sit with the facility to do the care plans but are never invited to the care plan meetings. The Hospice Physician stated hospice not being at the care plan meetings could have an affect the care of Resident #6 in which he might not receive the necessary care since he was on hospice.During an interview on 08/07/25 at 1:20 PM, with the Hospice SW, he stated hospice had not attended any actual care plan meetings for Resident #6. The Hospice SW stated the hospice was not part of the IDT nor were they invited to Resident #6's care plan meetings at the facility. The Hospice SW stated the family members wanted hospice to be part of the care plan meetings for Resident #6 and did not know why the facility was not having hospice as part of Resident #6's care plan. The Hospice SW stated it would be important for hospice to be present in the care plan meeting to discuss the services that would be provided to Resident #6. The Hospice SW stated not having hospice present could have services being missed for Resident #6.During an interview on 08/07/25 at 1:34 PM, with the Hospice Case Manager, he stated hospice had been invited to the care plan meeting in September 2025 but before that they had not been invited to any care plan meetings for Resident #6. The Hospice Case Manager stated they had been communicating with the DON and family regarding the review of the care plan and hospice does their own care plan for Resident #6. The Hospice Case Manager stated in the contract with the facility it stated in the delineation of duties that they have to be part of the IDT meetings which would be conducted by the physician, SW, RN, and spiritual care. The Hospice Case Manager stated the facility had a care plan for Resident #6 and it should have been correlating with the one that hospice had. The Hospice Case Manager stated any changes or deviations had to be reported to hospice so it would be updated in the hospice care plan.During an interview on 08/07/25 at 3:52 PM, with the Administrator, she stated the was SW was responsible and would be able to answer if residents who were on hospice had hospice invited to their care plan meetings. The Administrator stated as per facility policy hospice should have been invited to the care plan meeting(s). The Administrator stated the purpose of a care plan was to ensure that all the issues were addressed with all parts of care for the resident. The Administrator stated the care plan was a customized to meet the needs of each resident. The Administrator stated the negative outcome would be an area in care or services in the care plan being missed.During an interview on 08/18/25 at 1:13 PM, with the ADON, she stated the purpose of a care plan was to inform all departments and answer

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Resident #7) of 4 residents reviewed for ADL care for dependent residents.The facility failed to ensure the Hospice CNA provided perineal care with professional standards to ensure Resident #7 was clean, free of contamination. This failure placed residents who were dependent on staff for ADL care at risk for inappropriate transmission-based precautions to be used.Findings include: Record review of Resident #7's face sheet dated 08/18/25, revealed, admission on [DATE] to the facility. Record review of Resident #7's facility history and physical dated 05/14/25, revealed, an [AGE] year-old female diagnosed with Alzheimer's dementia with aggression and failure to thrive (a syndrome characterized by weight loss, poor nutrition, decreased activity, and a decline in overall functional ability, often accompanied by symptoms like depression and cognitive impairment). Record review of Resident #7's quarterly MDS dated [DATE], revealed, severe cognition of impairment BIMS of 6 to be able to recall or make daily decisions. Functional abilities were supervision or touching assistance (staff provides verbal cues and or touching/steadying and or contact guard assistance) with toileting. Resident #7 was always incontinent was urinary continence. Record review of Resident #7's care plan dated 05/14/25, revealed, had bladder incontinence related to activity intolerance. Monitor and document intake and output as per facility policy. Monitor fluid intake to determine if natural diuretics such as coffee, tea, or cola was contributing to increased urination and incontinence. Had terminal prognosis and under hospice's services related to atrial fibrillation. Consult with physician and social services to have hospice care for resident in the facility. Resident #7's ADLs was incontinent of bowel and bladder and required staff assist for cleansing and clothing. Observation on 08/07/25 at 6:11 AM, with Hospice CNA, revealed, perineal care was going to be provided to Resident #7 in her room. Hospice CNA entered the room and put on gloves and prepared the supplies to change Resident #7. Hospice CNA pulled several wipes from the package and placed them on top of the bed. Hospice CNA removed the soiled brief and disposed of it in the trashcan. Hospice CNA did not change gloves and did not perform hand hygiene. Hospice CNA proceeded to clean the resident's genital area with wipes from rectum to perineum (the area between the anus and vulva) and perineum to rectum. Hospice CNA cleaned buttock from front to back, it was observed that the wipes smeared with fecal matter, and she placed them on top of the clean wipes that were on the bed. that were on the bed. Hospice CNA disposed of dirty wipes in the trashcan and did not change gloves and did not perform hand hygiene. Hospice CNA put on the clean brief and continued to dress Resident #7. Hospice CNA was observed going through the drawers and closet with the contaminated gloves. Hospice CNA then proceeded to dress Resident #7, got her out of bed and sat her in the reclining Geri-chair. Hospice CNA then brushed Resident #7's hair. Hospice CNA then pulled the divider curtain with the contaminated gloves, put mousse on Resident #7's hair with the contaminated gloves, cleaned Resident #7's face and handed the resident a container of face cream so she could put cream on her face. During an interview on 08/07/25 at 6:35 AM, with the Hospice CNA, she stated she had been trained to clean the genital area from the top to the back and not go up and down with the same wipes to prevent contamination of the genital area. Hospice CNA said that she had been trained to change gloves and use hand sanitizer when she removed the soiled brief and dispose of the brief in the trash can. Hospice CNA said that she needed to change her gloves and use hand sanitizer each time that she removed the soiled gloves to prevent contamination by touching everything with the soiled gloves. Hospice CNA stated she had removed her gloves, entered the bathroom to wash her hands in the hand sink, and stated that the soap dispenser was empty. Hospice CNA stated she walked out of the bathroom and used hand sanitizer.During an interview on 08/18/25 at 10:25 AM, with the ADON, she stated when providing perineal care staff are to be washing their hands and putting on gloves. The ADON stated you start by cleaning the resident from front to back and make sure nothing gets soiled. The ADON stated then you throw away the soiled wipe and remove the gloves and clean your hands and reapply gloves. The ADON stated it would not be okay to be having dirty wipes on top of clean ones. The ADON stated not washing your hands and changing out your gloves could be a risk of infection. During an interview on 08/18/25 at 1:40 PM, with the DON, she stated she was the infection control preventionist. The DON stated when conducting perineal care, the staff had to wash their hands and talk to the resident letting them know what was going to happen

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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** Based on observation, interview, and record review the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #8) of 4 residents reviewed for accidents hazards.The facility failed to provide safe transfer assistance, using proper transfer techniques for Resident #8. CNA A and CNA B failed to secure the brakes on the mechanical lift prior to lifting Resident #8 off the wheelchair.This failure placed the resident at risk of injury from improper transfer techniques.The findings included:Record review of Resident #8's face sheet dated 08/18/25, revealed, admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #8's facility history and physical dated 06/05/25, revealed, a [AGE] year-old male diagnosed with dementia, degenerative disease of the central nervous system (a group of disorders where nerve cells in the brain and spinal cord progressively lose function, leading to a decline in physical and cognitive abilities), and Complete trisomy 21 syndrome (a genetic disorder where a person has a complete extra copy of chromosome 21 in all their cells, resulting from an error during the formation of egg or sperm). Record review of Resident #8's quarterly MDS dated [DATE], revealed, a BIMS was not taken to see the severity of impairment in cognition to be able to recall or make daily decision for Resident #8. It was not coded for mechanical lift. Functional abilities were dependent for roll left/right, sit to lying, lying to sitting on side bed, sit to stand, and chair/bed to chair transfer. Record review of Resident #8's care plan dated 05/17/25, revealed, ADLs self-care performance deficit related to down syndrome (a genetic condition where a person is born with an extra chromosome) and CVA (stroke occurs when a blood vessel in the brain becomes blocked or ruptures, cutting off blood flow to the brain). Transfer - extent/type may fluctuate within a day to day, depending on level of strength, pain, mood, etc. May require more staff assist or less. Resident was normally bedfast. Chair to bed dependent using 2 staff. On 08/06/25 at 8:30 AM a Facility Transfer, and ADLs Policy was requested from the Administrator and DON via e-mail but did not provide one of each by the facility. During an observation and interview on 08/06/25 at 10:27 AM, with CNA A and CNA B, revealed, Resident #8 was going to be transferred from his wheelchair to his bed. CNA B was heard providing instructions to Resident #8 of what was going to happen. CNA A was positioning the mechanical lift in between Resident #8's wheelchair while CNA B was ensuring the sling was placed appropriately underneath Resident #8. Once the mechanical lift was in position CNA A and CNA B began to hook up the sling to the mechanical lift. CNA A, without locking the mechanical lift brakes, began to lift Resident #8 into the air. CNA B moved the wheelchair and CNA A began to move Resident #8 over the bed and then began to lower Resident #8 down onto the bed. After the demonstration CNA A stated she had not locked the mechanical lift brakes. CNA B stated the mechanical lift brakes had to be locked or applied for the safety of Resident #8. CNA A stated not locking or applying the lift brakes could have resulted in injury to Resident #8. During an interview on 08/18/25 at 10:30 AM, with the ADON, she stated the DON/ADONs provide training on transfers to the staff. The ADON stated the mechanical lift brakes had to be applied when lifting a resident into the air for safety. The ADON stated staff should be ensuring the mechanical lift brakes are on before lifting a resident into the air. The ADON stated the risk could be injuries to the resident. During an interview on 08/18/25 at 1:40 PM, with the DON, she stated anytime a resident was going to be lifted into the air while using a mechanical lift the staff had to apply the mechanical lift brakes. The DON stated the negative impact of not applying the mechanical lift brakes could be the mechanical lift moving and possible injury to the resident. The DON stated the DON/ADONs were responsible for training staff on mechanical lifts.