STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675106	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that residents had the right to be treated with respect and dignity and to be cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, for 1 (Resident #8) of 11 residents reviewed for being treated with dignity and respect. The facility failed to ensure that an unidentified nurse staff did not enter Resident #8's room at an unidentified time and date without permission after knocking, leaving him without time to put on clothing. This failure put residents at risk of embarrassment, decreased self-esteem, and loss of a sense of independence and control. Findings included: Record review of Resident #8's face sheet dated 04/03/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #8's History and Physical dated 07/29/2023 revealed he had diabetes, multiple amputations to his right foot, and was being treated for a non-healing wound. Record review of Resident #8's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 15 (cognitively intact). He had adequate eyesight and wore glasses. He had no symptoms of delirium (confused thinking and reduced awareness) or psychosis (disconnection from reality) . He had verbal behaviors directed towards others and had rejected care 1 to 3 days during the seven-day look-back period. He did not use any mobility devices (walker, wheelchair). He was independent in all his activities of daily living including walking, dressing, and bathing. He had no history of falls. Record review of Resident #8's care plan dated 02/27/2024 revealed he had a history of making false accusations. Interventions included documenting his concerns and addressing them through grievances. His care plan dated 03/04/2024 revealed he made negative statements about staff. Record review of Resident #8's Social Service progress note dated 03/25/2024 revealed the resident said he wants staff to knock on the door before entering the room and he needs to allow staff to enter. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's Social Service progress note dated 02/27/2024 revealed the resident said the 10-6 nurse went inside his room without his approval and he was naked. He reported that the nurse exited the room and later he went to the nurse's station and the nurse refused to give her name. Record review of Resident #8's Behavior note dated 02/26/2024 revealed he was upset that a nurse knocked on his door and came into his room. The nurse said she wanted to check to make sure he had not fallen because he had a high risk for falls. Record review of grievances dated 02/27/2024 revealed that the Ombudsman reported a grievance on the part of Resident #8 stating that on 02/26/2024 a female nurse when a female nurse went into his room without proper consent and the resident was naked. Per Summary/Findings on the document the resident had pressed the call light, and the nurse entered after knocking. Staff were in-serviced on resident rights. In-services were documented as being provided on 02/26/2024. Record review of grievances dated 03/25/2024 revealed that Resident #8 had reported that when staff knock, they have to wait until he answers to get consent to go inside. Another note on the grievance form included the name and telephone number of the state ombudsman. No other notes were seen on the grievance form. In a telephone interview on 04/03/2024 at 11:09 AM the Ombudsman reported that Resident #8 had contacted him about an incident on 02/26/2024 regarding a nurse entering his room when the resident was naked, and that later the nurse refused to give the resident her name. The Ombudsman said a grievance had been filed. In response the Ombudsman went to the facility and spoke to the DON and Social Worker. During the interview by the Ombudsman with the DON, the Social Worker and the resident present, the DON became upset and said the resident was a rude man and a liar, and that the conversation was over. At that point the resident said to just leave it so no further action was documented taken. In an interview on 04/03/3034 at 11:39 AM Resident #8 revealed that 3-4 days before he saw the Ombudsman [Social Service Progress Note 2/27/24] a tall, heavy woman knocked on his door in the early morning around 7:30 AM and just walked in. The resident said he had just finished showering and was naked. The nurse said she had his morning medication, and when the resident said it was not time for his AM medications, the nurse said it was for another resident. The resident said he was not able to get her name and that later when he asked for her name, she refused to give it to him. In an interview on 4/3/24 at 2:08 PM the Social Worker revealed that when a grievance was received it was routed to the corresponding department and the department then reports actions and outcomes to the Social Worker. Regarding Resident #8, the Social Worker said he was concerned that someone knocked on door and came in without permission. The resident did not tell the Social Worker he was not dressed. According to the Social Worker she (the Social Worker and the Administrator) recommended to staff that they knock and wait for OK to enter the room. Per the Social Worker the nurse alleged to have entered the room was a male nurse, who said that the resident was refusing medications. The Social Worker said that staff have a right to go into resident's rooms. She said that staff should wait to see if they answer, and that if there was no answer staff should enter the room in case something has happened to the resident such as a fall. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone call was made to LVN A (female nurse) on 04/03/2024 at 2:52 PM who documented administration of medications to Resident #8 the morning of 02/25/2024. A message was left requesting a call back. No call was received back prior to exit. A telephone call was made to LVN B (male nurse) on 04/03/2024 at 2:55 PM who documented administration of medications to Resident #8 the morning of 02/26/2024. A message was left requesting a call back. No call was received back prior to exit. In a follow up interview on 4/3/2024 at 3:38 PM the Social Worker revealed that in response to the grievance from Resident #8 dated 03/25/2024 regarding staff members not knocking or waiting for permission to enter the room, the Social Worker and Administrator went and talked to the resident and a call was made to the state ombudsman, from whom the facility had not received a call back, so the grievance had not been resolved. The Social Worker said that there can be problems when a resident does not respond to knocks, that perhaps the resident had fallen or had some medical problem. In an interview on 04/03/2024 at 4:07 PM the Administrator revealed that if a resident turns on the call light staff need to respond. She said that staff need to knock on the resident's door and should wait for permission to enter the room but if there was no response there may be an emergent situation so staff may need to go in without permission. She stated that Resident #8 had a history of falls so when he does not respond to knocking on his door staff need to enter to make sure he is OK. Record review of the facility policy Resident Rights (undated) revealed that the resident has a right to a dignified existence. A facility must treat resident with respect and dignity and to be cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on interview and record review the facility failed to ensure that residents had the right to receive unopened mail and other letters, packages and other materials delivered to the facility for the resident for one (Resident #8) of 11 residents reviewed for receiving unopened mail and other materials delivered to the facility for the resident. The facility failed to ensure that Resident #8 received an unopened personal correspondence. This failure places residents at risk of violations of their right to privacy due to their letters and packages being opened before they are delivered to the resident. Findings included: Record review of Resident #8's face sheet dated 04/03/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #8's History and Physical dated 07/29/2023 revealed he had diabetes, multiple amputations to his right foot, and was being treated for a non-healing wound. Record review of Resident #8's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 15 (cognitively intact). He had adequate eyesight and wore glasses. He had no symptoms of delirium (confused thinking and reduced awareness) or psychosis (disconnection from reality). He had verbal behaviors directed towards others and had rejected care 1 to 3 days during the seven day look-back period. He did not use any mobility devices (walker, wheelchair). He was independent in all his activities of daily living including walking, dressing, and bathing. He had no history of falls. Record review of Resident #8's care plan dated 02/27/2024 revealed he had a history of making false accusations. Interventions included documenting his concerns and addressing them through grievances. His care plan dated 03/04/3034 revealed he made negative statements about staff. Record review of a grievance dated 03/18/2024 revealed that Resident #8 had expressed concern that his letter was open. The Social Worked attempted to meet with the Resident #8 but he did not respond when she knocked on his door. The resolution was that the Activity Director would deliver all Resident #8's mail personally. In a telephone interview on 04/03/2024 at 11:09 AM the Ombudsman revealed that Resident #8 had contacted him saying he had received a letter from his family member that was already open. The Ombudsman said he was not asked to take action but educated the resident about his rights. The resident reported to the Ombudsman that the Administrator had asked to see the letter when the concern was mentioned. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/03/2024 at 11:39 PM Resident #8 revealed he had received a letter from a family member that was opened before the facility gave it to him. The resident said he had asked his family member to send the letter to him so he could check on whether it would arrive unopened. Resident #8 said when the letter was received opened, he went and asked why this had happened. The resident said he was told that the front desk sends mail to Business Office. The Business Office said that the Activities Director had opened the letter. The Activities Director said the Business Office had opened it. Resident #8 said he asked the Administrator who later went to his room with the Social Worker, and that they had told him they would bring him his mail unopened. In an interview on 04/03/2024 at 1:53 PM the BOM Assistant revealed she started working on 02/26/2024. She stated that she opens all the mail that comes in except for some residents. She said she did not open mail for some residents because they were on a list. In an interview on 04/03/2024 at 1:57 PM the BOM revealed she started working in 12/2023. She said that the business office opened all mail except for that for a few residents, the ones that are on the list from the in-service. She stated that mail was opened for residents for whom the facility was representative payee (acted as a as the receiver of Social Security for persons who are not capable of handling their own benefits). The BOM stated they open mail sometimes to see who it was for. The BOM stated that the BOM Assistant had opened Resident #8's mail in error, and that the resident was upset that it arrived open. The BOM said that it was a violation of resident rights to open their mail without their permission. Record review of the document In-Service Training Record dated 03/18/2024 revealed The following residents open their own mail: [names of four residents, including Resident #8] * If you are unsure, ask the business office manager.* In an interview on 04/03/2024 at 2:08 PM the Social Worker revealed she had talked with Resident #8 about him receiving the opened mail. She said it was a resident's right to receive unopened mail. In interview and record review on 04/03/2024 at 2:37 PM the BOM provided a list with highlights over the names of residents for whom the facility was representative payee. The BOM confirmed verbally that the Business Office opened mail for all residents unless the resident was on the list provided during the in-service. Record review of the document Deposit Transaction Report received from the BOM on 04/03/2024 at 2:37 PM (document dates 4/3/2024, 3:59 PM). The document had the names of six residents highlighted. In an interview on 04/03/2024 at 3:04 PM the Activities Director revealed that the BOM Assistant gave her the mail and she delivered it to the residents that asked that their mail not be opened first. She said she did not deliver mail to any other person. In an interview on 04/03/2024 at 4:07 PM with the Administrator and BOM the Administrator revealed that mail should be delivered to residents unopened. She stated that the facility does not open resident's mail unless the facility was representative payee. The BOM stated the facility only opened mail for residents for whom the facility was representative payee, and denied saying that the facility opened all resident's mail. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interviews on 4/4/24 with four residents they revealed they did not receive their mail at the facility. In an interview on 4/4/24 at 8:15 AM Resident #8 revealed he had not had any other mail delivered to him opened. He said the only mail that had been delivered to him open was the letter from his family member. Record review of the facility policy Resident Rights (undated) revealed that residents have a right to promptly receive unopened mail and other letters.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review, the facility failed to ensure residents were free from abuse when an altercation occurred on 2/26/24 between two residents (Resident #1 and Resident #2) of 11 reviewed for implementation of policies that prevent abuse. 1. The facility failed to investigate an altercation on 2/26/2024 at 9:29 AM between Resident #1 and #2. 2. The facility failed to protect Resident #1 from Resident #2 resulting in a resident-to-resident physical altercation on 02/26/2024 at 1:00 PM. This failure puts residents at risk of physical altercations that could result in injury. Findings included: Record review of the facility form 3613-A dated regarding an incident on 02/26/2024 at 1:00 PM revealed that it involved Resident #1 and Resident #2. Per the report Resident #2 made contact with Resident #1's left cheek when he became agitated that he was talking to Resident #1 and Resident #1 was ignoring him. The report stated that Resident #1 and Resident #2 were seated next to each other and Resident #2 wanted to know why Resident #1 had passed by his room. When Resident #1 did not respond to Resident #2, Resident #2 used his right hand to make contact with the left side of Resident #1's face. Both residents were assessed and neither had emotional or physical injuries. Resident #2 was sent for in-patient psychiatric assessment at a local geriatric behavioral unit. Record review of Resident #1's Face Sheet dated 03/21/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's Physicians Progress Note dated 02/20/2024 revealed the resident continued to be confused and was oriented only to himself. Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 4 (severe cognitive impairment). Face Sheet dated revealed he had symptoms of delirium including intermittent inattention and disorganized thinking. He had no indicators of psychosis (disconnection from reality). He had verbal behavioral symptoms directed toward others 1-3 days of the 7-day look-back period. He had no impairment to his upper or lower body and used a walker or a wheelchair to move around the facility. He required moderate assistance for toileting, showering, and upper and lower body dressing. He required moderate assistance for moving between surfaces and for walking. Record review of Resident #1's History and Physical dated 04/08/2023 revealed he had been in the hospital for aggressive behavior. He had diagnoses including dementia, anxiety, major depressive disorder, and delusional disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 04/10/2023 revealed he had revealed he had episodes of anxiety and was at risk for fluctuation in moods. Interventions included to monitor and report any mental status changes that occur with resident, place in a quiet area when anxiety occurs and to redirect for each episode. His care plan revised on 02/19/2024 revealed he had cognitive impairment evidenced by a diagnosis of dementia, impaired Ability to Make decisions, risk for Impaired Communication, Difficulty Expressing Needs, Episodes of Disorganized thinking, Episodes of Inattention, and Impaired Safety Awareness. Care plan dated 04/25/2023 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, using racial slurs, yelling/screaming, and being physically aggressive, hitting, pinching, kicking, and throwing objects. Interventions included to anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression, monitor for early warning signs of behavior, and remove from unwanted stimuli to a safe environment. Care plan initiated 03/12/2024 revealed he was at risk for wandering due to dementia. The goal was that he would not leave the facility unattended. Interventions included to distract him by offering pleasant diversion and if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Record review of Resident #1's progress notes dated 12/9/2023 at 9:11 PM revealed the resident was pacing/ wandering in the hallway anxious and a refused shower. Record review of Resident #1's progress notes dated 12/10/2023 at 9:39 PM revealed the resident was pacing/ wandering in the hallway anxious, looking for the door. Stated Oiga ya me tengo que ir donde esta la [NAME], el tractor esta afuera (Listen, I have to go now. Where is the door? The tractor/truck is outside). Resident redirected unsuccessfully. Record review of Resident #1's progress notes dated 01/13/2024 at 11:50 AM revealed the resident was very anxious, pacing and entering other resident rooms, verbally aggressive to staff, using vulgar language. Attempts at redirection unsuccessful. Record review of Resident #1's progress notes dated 2/25/2024 at 1:19 PM revealed the resident was in a wheelchair wandering in the hallway. He was placed in bed several times as per his request but kept trying to get back out of bed so was put back in the wheelchair. Record review of Resident #1's progress notes dated 2/26/2024 at 1:45 PM revealed that at around 12:50 PM a resident [Resident #2] began to raise his voice towards Resident #1. LVN C was in dining room providing assisted dining to another resident. As LVN C rose to intervene, Resident #2 grabbed Resident #1 by the right arm and struck Resident #1 in the left cheek. Record review of Resident #2's face sheet dated 03/21/2024 revealed that he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's History and Physical dated 03/21/2024 revealed he had diagnoses including Parkinson's disease, depression, and anxiety. He was oriented to self. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's electronic diagnosis listing accessed 3/21/2024 revealed he had additional diagnoses including schizoaffective (a mental disorder with schizophrenic symptoms like hallucinations, combined with mood disorder symptoms such as depression or extremely elevated mood) mania - disorder, bipolar type; and unspecified dementia, mild, with other behavioral disturbance. He had no symptoms of delirium (confused thinking and reduced awareness) or psychosis (disconnection from reality) Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 13 (cognitively intact). He had intermittent periods of inattention. He had no symptoms of psychosis (disconnection from reality) and not behavioral symptoms during the 7-day look-back period. He had no impairment to his upper or lower body and used a wheelchair as a mobility device. He required moderate assistance for toileting and bathing, and set-up or supervision assistance for dressing. He required set-up for transfers between surfaces and supervision to walk. Record review of Resident #2's care plan revised on 02/12/2024 revealed he used psychotropic medications and staff were to monitor and record the occurrence of target behavior symptoms such as inappropriate response to verbal communication, violence/aggression towards staff/others. His care plan revised 03/13/2022 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, yelling/screaming, and being physically aggressive such as hitting, pinching, kicking, throwing objects toward staff. Revision to the care plan 03/19/2024 indicated that on 02/26/2024 Resident #2 was involved in a resident-to-resident altercation which resulted in him being transported to GBU for inpatient psych treatment. Interventions to address his adverse behavior included to anticipate behaviors and redirect when in close proximity to others that might invoke aggression and to monitor for early warning signs of behavior, approach in calm manner, call by name, and to remove him from the unwanted stimuli to a safe environment. Record review of Resident #2's Progress Note written by LVN C dated 2/26/2024 at 09:29 AM revealed that Resident #2 had a verbal argument with Resident #1 and was verbally aggressive stating te [NAME] a partir la madre [I'm going to kick your ass] to Resident #1. Resident #1 was wheeling himself down the hall and did make his way into Resident #2's room when Resident #2 began to yell at Resident #1. Residents were separated. Record review of Resident #2's Progress Notes written by LVN C dated 2/26/2024 at 1:37 PM revealed that in the dining room at around 12:50 PM Resident #2 began to raise his voice towards Resident #1. LVN C was in dining room providing assisted dining to another resident. As LVN C rose to intervene, Resident #2 grabbed Resident #1 by the right arm and struck Resident #1 in the left cheek. Record review of Resident #2's Progress Noted dated 2/26/2024 at 1:56 PM revealed that the Social Worker met with Resident #2 to follow up on an incident that occurred in the dining area with Resident #1. Resident #2 stated that Resident #1 started in the morning when he brought an ice chest filled with ice into Resident #2's room, and also broke his glasses. Resident #2 said he asked Resident #1 to leave his room, so Resident #1 left. Record review of Resident #1's dating back one year and Resident #2's progress notes dating back one year showed no prior or more recent altercations between the residents before or after the altercations on 02/26/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observation and interview on 3/19/2024 at 9:25 AM Resident #1 was found standing in the doorway to his room. When Surveyor D asked about bruises and falling the resident displayed symptoms of agitation (based on raising voice, clenching fists, and bending arms at elbows) three times during a brief conversation. He was redirected and calmed down each time he began to become anxious. In an interview on 03/19/2024 at 9:50 AM Resident #2 was found in his room in a wheelchair. He stated that he had been moved to another floor because a male resident [name unknown] had come into his room with a wheelchair full of ice. Resident #2 yelled at the other resident to get out, but resident would not. Resident #2 stated the other resident broke his glasses but was not able to explain how. Resident #2 said he called for help, but staff did not come. The male resident who had entered Resident #2's room with a wheelchair with ice it then left the room. In an interview and observation on 03/22/2024 at 10:24 AM LVN C revealed that on 2/26/2024 at 9:29 AM he heard Resident #2 say to Resident #1 te [NAME] a partir la madre which was a threat and was swearing, which LVN C translated as meaning I'm going to 'F' you up. The LVN stated that the two residents were separated with Resident #1 being kept in line of sight because he was mobile and had dementia. LVN C said that the verbal threat by one resident to another should have been reported because it was verbal abuse. LVN C stated he did not remember if he reported the incident on 02/26/2024 at 9:29 AM to anyone. LVN C also stated that he was present on 02/26/2024 at around 12:50 PM in the third-floor dining room when Resident #1 went into the dining room and began talking with another resident. Observation on 03/22/2024 at 10:27 AM of the dining room revealed that Resident #1 was about five feet away from where Resident #2 was seated. According to LVN C Resident #2 began to speak to Resident #1 in a normal voice but then both residents began to raise their voices. LVN C stated that at that point he stood up to intervene, but that Resident #2 moved toward Resident #1, grabbed him by the right arm of his sweater and hit Resident #1 in the face. In an interview on 03/22/2024 at 10:55 AM the Administrator revealed she was the Abuse Coordinator. She stated the argument between Resident #1 and #2 the morning of 02/26/24 in which Resident #2 stated to Resident #1 te [NAME] a partir la madre was not reported to her. The Administrator stated she believed the phrase meant I am going to kick your ass but that whether it should have been reported to her depended on LVN C's understanding of the phrase. She stated that the incident the morning of 02/26/2024 was not investigated. When asked if Resident #1 and Resident #2 were protected from each other at lunch time on 02/26/2024 she said she did not have an exact impression of what took place. She said, We are told to investigate abuse to determine root cause, how can we put a plan in place to maintain safety for all parties involved. Record review of the facility Abuse/Neglect revised 03/29/2018 revealed that the resident has the right to be free from abuse. Residents should not be subjected to abuse from anyone, including other residents. The facility will provide and ensure the protection of resident rights. It is each individual's responsibility to recognize and report actual or alleged abuse and situations that may constitute abuse of any resident in the facility. Verbal abuse examples include threats of harm. The facility will identify and investigate events that my constitute abuse/neglect. The facility will take necessary measures to protect residents from harm during and following an abuse investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675106	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review the facility failed to implement written policies that prohibit and prevent abuse, neglect, and exploitation of residents for two residents (Resident #1 and Resident #2) of 11 reviewed for implementation of policies that prevent abuse. 1. The facility failed to investigate altercation on 2/26/2024 at 9:29 AM between Resident #1 and #2. 2. The facility failed to protect Resident #1 from Resident #2 resulting in a resident-to-resident physical altercation on 02/26/2024 at 1:00 PM. This failure puts residents at risk of physical altercations that could result in injury. Findings included: Record review of the facility Abuse/Neglect revised 03/29/2018 revealed that the resident has the right to be free from abuse. Residents should not be subjected to abuse from anyone, including other residents. The facility will provide and ensure the protection of resident rights. It is each individual's responsibility to recognize and report actual or alleged abuse and situations that may constitute abuse of any resident in the facility. Verbal abuse examples include threats of harm. The facility will identify and investigate events that my constitute abuse/neglect. The facility will take necessary measures to protect residents from harm during and following an abuse investigation. Record review of the facility form 3613-A dated regarding an incident on 02/26/2024 at 1:00 PM revealed that it involved Resident #1 and Resident #2. Per the report Resident #2 made contact with Resident #1's left cheek when he became agitated that he was talking to Resident #1 and Resident #1 was ignoring him. The report stated that Resident #1 and Resident #2 were seated next to each other and Resident #2 wanted to know why Resident #1 had passed by his room. When Resident #1 did not respond to Resident #2, Resident #2 used his right hand to make contact with the left side of Resident #1's face. Both residents were assessed and neither had emotional or physical injuries. Resident #2 was sent for in-patient psychiatric assessment at a local geriatric behavioral unit. Record review of Resident #1's Face Sheet dated 03/21/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's Physicians Progress Note dated 02/20/2024 revealed the resident continued to be confused and was oriented only to himself. Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 4 (severe cognitive impairment). Face Sheet dated revealed he had symptoms of delirium including intermittent inattention and disorganized thinking. He had no indicators of psychosis (disconnection from reality). He had verbal behavioral symptoms directed toward others 1-3 days of the 7-day look-back period. He had no impairment to his upper or lower body and used a walker or a wheelchair to move around the facility. He required moderate assistance for toileting, showering, and upper and lower body dressing. He required moderate assistance for moving between surfaces and for walking. (continued on next page)

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Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's History and Physical dated 04/08/2023 revealed he had been in the hospital for aggressive behavior. He had diagnoses including dementia, anxiety, major depressive disorder, and delusional disorder. Record review of Resident #1's care plan dated 04/10/2023 revealed he had revealed he had episodes of anxiety and was at risk for fluctuation in moods. Interventions included to monitor and report any mental status changes that occur with resident, place in a quiet area when anxiety occurs and to redirect for each episode. His care plan revised on 02/19/2024 revealed he had cognitive impairment evidenced by a diagnosis of dementia, impaired Ability to Make decisions, risk for Impaired Communication, Difficulty Expressing Needs, Episodes of Disorganized thinking, Episodes of Inattention, and Impaired Safety Awareness. Care plan dated 04/25/2023 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, using racial slurs, yelling/screaming, and being physically aggressive, hitting, pinching, kicking, and throwing objects. Interventions included to anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression, monitor for early warning signs of behavior, and remove from unwanted stimuli to a safe environment. Care plan initiated 03/12/2024 revealed he was at risk for wandering due to dementia. The goal was that he would not leave the facility unattended. Interventions included to distract him by offering pleasant diversion and if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Record review of Resident #1's progress notes dated 12/9/2023 at 9:11 PM revealed the resident was pacing/ wandering in the hallway anxious and a refused shower. Record review of Resident #1's progress notes dated 12/10/2023 at 9:39 PM revealed the resident was pacing/ wandering in the hallway anxious, looking for the door. Stated Oiga ya me tengo que ir donde esta la [NAME], el tractor esta afuera (Listen, I have to go now. Where is the door? The tractor/truck is outside). Resident redirected unsuccessfully. Record review of Resident #1's progress notes dated 01/13/2024 at 11:50 AM revealed the resident was very anxious, pacing and entering other resident rooms, verbally aggressive to staff, using vulgar language. Attempts at redirection unsuccessful. Record review of Resident #1's progress notes dated 2/25/2024 at 1:19 PM revealed the resident was in a wheelchair wandering in the hallway. He was placed in bed several times as per his request but kept trying to get back out of bed so was put back in the wheelchair. Record review of Resident #1's progress notes dated 2/26/2024 at 1:45 PM revealed that at around 12:50 PM a resident [Resident #2] began to raise his voice towards Resident #1. LVN C was in dining room providing assisted dining to another resident. As LVN C rose to intervene, Resident #2 grabbed Resident #1 by the right arm and struck Resident #1 in the left cheek. Record review of Resident #2's face sheet dated 03/21/2024 revealed that he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's History and Physical dated 03/21/2024 revealed he had diagnoses including Parkinson's disease, depression, and anxiety. He was oriented to self. (continued on next page)

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	675106	A. Building B. Wing	04/04/2024

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Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's electronic diagnosis listing accessed 3/21/2024 revealed he had additional diagnoses including schizoaffective (a mental disorder with schizophrenic symptoms like hallucinations, combined with mood disorder symptoms such as depression or extremely elevated mood) mania - disorder, bipolar type; and unspecified dementia, mild, with other behavioral disturbance. He had no symptoms of delirium (confused thinking and reduced awareness) or psychosis (disconnection from reality) Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 13 (cognitively intact). He had intermittent periods of inattention. He had no symptoms of psychosis (disconnection from reality) and not behavioral symptoms during the 7-day look-back period. He had no impairment to his upper or lower body and used a wheelchair as a mobility device. He required moderate assistance for toileting and bathing, and set-up or supervision assistance for dressing. He required set-up for transfers between surfaces and supervision to walk. Record review of Resident #2's care plan revised on 02/12/2024 revealed he used psychotropic medications and staff were to monitor and record the occurrence of target behavior symptoms such as inappropriate response to verbal communication, violence/aggression towards staff/others. His care plan revised 03/13/2022 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, yelling/screaming, and being physically aggressive such as hitting, pinching, kicking, throwing objects toward staff. Revision to the care plan 03/19/2024 indicated that on 02/26/2024 Resident #2 was involved in a resident-to-resident altercation which resulted in him being transported to GBU for inpatient psych treatment. Interventions to address his adverse behavior included to anticipate behaviors and redirect when in close proximity to others that might invoke aggression and to monitor for early warning signs of behavior, approach in calm manner, call by name, and to remove him from the unwanted stimuli to a safe environment. Record review of Resident #2's Progress Note written by LVN C dated 2/26/2024 at 09:29 AM revealed that Resident #2 had a verbal argument with Resident #1 and was verbally aggressive stating te [NAME] a partir la madre [I'm going to kick your ass] to Resident #1. Resident #1 was wheeling himself down the hall and did make his way into Resident #2's room when Resident #2 began to yell at Resident #1. Residents were separated. Record review of Resident #2's Progress Notes written by LVN C dated 2/26/2024 at 1:37 PM revealed that in the dining room at around 12:50 PM Resident #2 began to raise his voice towards Resident #1. LVN C was in dining room providing assisted dining to another resident. As LVN C rose to intervene, Resident #2 grabbed Resident #1 by the right arm and struck Resident #1 in the left cheek. Record review of Resident #2's Progress Noted dated 2/26/2024 at 1:56 PM revealed that the Social Worker met with Resident #2 to follow up on an incident that occurred in the dining area with Resident #1. Resident #2 stated that Resident #1 started in the morning when he brought an ice chest filled with ice into Resident #2's room, and also broke his glasses. Resident #2 said he asked Resident #1 to leave his room, so Resident #1 left. In observation and interview on 3/19/2024 at 9:25 AM Resident #1 was found standing in the doorway to his room. When Surveyor D asked about bruises and falling the resident displayed symptoms of agitation (based on raising voice, clenching fists, and bending arms at elbows) three times during a brief conversation. He was redirected and calmed down each time he began to become anxious. (continued on next page)

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Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/2024 at 9:50 AM Resident #2 was found in his room in a wheelchair. He stated that he had been moved to another floor because a male resident [name unknown] had come into his room with a wheelchair full of ice. Resident #2 yelled at the other resident to get out, but resident would not. Resident #2 stated the other resident broke his glasses but was not able to explain how. Resident #2 said he called for help, but staff did not come. The male resident who had entered Resident #2's room with a wheelchair with ice it then left the room. In an interview and observation on 03/22/2024 at 10:24 AM LVN C revealed that on 2/26/2024 at 9:29 AM he heard Resident #2 say to Resident #1 te [NAME] a partir la madre which was a threat and was swearing, which LVN C translated as meaning I'm going to 'F' you up. The LVN stated that the two residents were separated with Resident #1 being kept in line of sight because he was mobile and had dementia. LVN C said that the verbal threat by one resident to another should have been reported because it was verbal abuse. LVN C stated he did not remember if he reported the incident on 02/26/2024 at 9:29 AM to anyone. LVN C also stated that he was present on 02/26/2024 at around 12:50 PM in the third-floor dining room when Resident #1 went into the dining room and began talking with another resident. Observation on 03/22/2024 at 10:27 AM of the dining room revealed that Resident #1 was about five feet away from where Resident #2 was seated. According to LVN C Resident #2 began to speak to Resident #1 in a normal voice but then both residents began to raise their voices. LVN C stated that at that point he stood up to intervene, but that Resident #2 moved toward Resident #1, grabbed him by the right arm of his sweater and hit Resident #1 in the face. In an interview on 03/22/2024 at 10:55 AM the Administrator revealed she was the Abuse Coordinator. She stated the argument between Resident #1 and #2 the morning of 02/26/24 in which Resident #2 stated to Resident #1 te [NAME] a partir la madre was not reported to her. The Administrator stated she believed the phrase meant I am going to kick your ass but that whether it should have been reported to her depended on LVN C's understanding of the phrase. She stated that the incident the morning of 02/26/2024 was not investigated. When asked if Resident #1 and Resident #2 were protected from each other at lunch time on 02/26/2024 she said she did not have an exact impression of what took place. She said, We are told to investigate abuse to determine root cause, how can we put a plan in place to maintain safety for all parties involved.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse are reported immediately, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials for two residents (Resident #1 and Resident #2) of 11 reviewed for implementation of policies that prevent abuse. LVN C failed to report an alterction between Resident #1 and #2 that took place the morning of 02/23/2024 to the Administrator. This failure puts residents at risk of physical altercations that could result in injury. Findings included: Record review of the facility form 3613-A dated regarding an incident on 02/26/2024 at 1:00 PM revealed that it involved Resident #1 and Resident #2. Per the report Resident #2 made contact with Resident #1's left cheek when he became agitated that he was talking to Resident #1 and Resident #1 was ignoring him. The report stated that Resident #1 and Resident #2 were seated next to each other and Resident #2 wanted to know why Resident #1 had passed by his room. When Resident #1 did not respond to Resident #2, Resident #2 used his right hand to make contact with the left side of Resident #1's face. Both residents were assessed and neither had emotional or physical injuries. Resident #2 was sent for in-patient psychiatric assessment at a local geriatric behavioral unit. Record review of Resident #1's Face Sheet dated 03/21/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's Physicians Progress Note dated 02/20/2024 revealed the resident continued to be confused and was oriented only to himself. Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 4 (severe cognitive impairment). Face Sheet dated revealed he had symptoms of delirium including intermittent inattention and disorganized thinking. He had no indicators of psychosis (disconnection from reality). He had verbal behavioral symptoms directed toward others 1-3 days of the 7-day look-back period. He had no impairment to his upper or lower body and used a walker or a wheelchair to move around the facility. He required moderate assistance for toileting, showering, and upper and lower body dressing. He required moderate assistance for moving between surfaces and for walking. Record review of Resident #1's History and Physical dated 04/08/2023 revealed he had been in the hospital for aggressive behavior. He had diagnoses including dementia, anxiety, major depressive disorder, and delusional disorder. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 04/10/2023 revealed he had revealed he had episodes of anxiety and was at risk for fluctuation in moods. Interventions included to monitor and report any mental status changes that occur with resident, place in a quiet area when anxiety occurs and to redirect for each episode. His care plan revised on 02/19/2024 revealed he had cognitive impairment evidenced by a diagnosis of dementia, impaired Ability to Make decisions, risk for Impaired Communication, Difficulty Expressing Needs, Episodes of Disorganized thinking, Episodes of Inattention, and Impaired Safety Awareness. Care plan dated 04/25/2023 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, using racial slurs, yelling/screaming, and being physically aggressive, hitting, pinching, kicking, and throwing objects. Interventions included to anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression, monitor for early warning signs of behavior, and remove from unwanted stimuli to a safe environment. Care plan initiated 03/12/2024 revealed he was at risk for wandering due to dementia. The goal was that he would not leave the facility unattended. Interventions included to distract him by offering pleasant diversion and if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Record review of Resident #2's face sheet dated 03/21/2024 revealed that he was [AGE] years old, was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's History and Physical dated 03/21/2024 revealed he had diagnoses including Parkinson's disease, depression, and anxiety. He was oriented to self. Record review of Resident #2's electronic diagnosis listing accessed 3/21/2024 revealed he had additional diagnoses including schizoaffective (a mental disorder with schizophrenic symptoms like hallucinations, combined with mood disorder symptoms such as depression or extremely elevated mood) mania - disorder, bipolar type; and unspecified dementia, mild, with other behavioral disturbance. He had no symptoms of delirium (confused thinking and reduced awareness) or psychosis (disconnection from reality) Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 13 (cognitively intact). He had intermittent periods of inattention. He had no symptoms of psychosis (disconnection from reality) and not behavioral symptoms during the 7-day look-back period. He had no impairment to his upper or lower body and used a wheelchair as a mobility device. He required moderate assistance for toileting and bathing, and set-up or supervision assistance for dressing. He required set-up for transfers between surfaces and supervision to walk. Record review of Resident #2's care plan revised on 02/12/2024 revealed he used psychotropic medications and staff were to monitor and record the occurrence of target behavior symptoms such as inappropriate response to verbal communication, violence/aggression towards staff/others. His care plan revised 03/13/2022 revealed he had episodes of adverse behavior such as being verbally aggressive, cursing, yelling/screaming, and being physically aggressive such as hitting, pinching, kicking, throwing objects toward staff. Revision to the care plan 03/19/2024 indicated that on 02/26/2024 Resident #2 was involved in a resident-to-resident altercation which resulted in him being transported to GBU for inpatient psych treatment. Interventions to address his adverse behavior included to anticipate behaviors and redirect when in close proximity to others that might invoke aggression and to monitor for early warning signs of behavior, approach in calm manner, call by name, and to remove him from the unwanted stimuli to a safe environment. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Progress Note written by LVN C dated 2/26/2024 at 09:29 AM revealed that Resident #2 had a verbal argument with Resident #1 and was verbally aggressive stating te [NAME] a partir la madre [I'm going to kick your ass] to Resident #1. Resident #1 was wheeling himself down the hall and did make his way into Resident #2's room when Resident #2 began to yell at Resident #1. Residents were separated. Record review of Resident #2's Progress Noted dated 2/26/2024 at 1:56 PM revealed that the Social Worker met with Resident #2 to follow up on an incident that occurred in the dining area with Resident #1. Resident #2 stated that Resident #1 started in the morning when he brought an ice chest filled with ice into Resident #2's room, and also broke his glasses. Resident #2 said he asked Resident #1 to leave his room, so Resident #1 left. Record review of Resident #1's progress notes dating back one year and Resident #2's progress notes dating back one year showed no other altercations between the residents before or after the altercations on 02/26/2024. In observation and interview on 3/19/2024 at 9:25 AM Resident #1 was found standing in the doorway to his room. When Surveyor D asked about bruises and falling the resident displayed symptoms of agitation (based on raising voice, clenching fists, and bending arms at elbows) three times during a brief conversation. He was redirected and calmed down each time he began to become anxious. In an interview on 03/19/2024 at 9:50 AM Resident #2 was found in his room in a wheelchair. He stated that he had been moved to another floor because a male resident [name unknown] had come into his room with a wheelchair full of ice. Resident #2 yelled at the other resident to get out, but resident would not. Resident #2 stated the other resident broke his glasses but was not able to explain how. Resident #2 said he called for help, but staff did not come. The male resident who had entered Resident #2's room with a wheelchair with ice it then left the room. In an interview and observation on 03/22/2024 at 10:24 AM LVN C revealed that on 2/26/2024 at 9:29 AM he heard Resident #2 say to Resident #1 te [NAME] a partir la madre which was a threat and was swearing, which LVN C translated as meaning I'm going to 'F' you up. The LVN stated that the two residents were separated with Resident #1 being kept in line of sight because he was mobile and had dementia. LVN C said that the verbal threat by one resident to another should have been reported because it was verbal abuse. LVN C stated he did not remember if he reported the incident on 02/26/2024 at 9:29 AM to anyone. LVN C also stated that he was present on 02/26/2024 at around 12:50 PM in the third-floor dining room when Resident #1 went into the dining room and began talking with another resident. Observation on 03/22/2024 at 10:27 AM of the dining room revealed that Resident #1 was about five feet away from where Resident #2 was seated. According to LVN C Resident #2 began to speak to Resident #1 in a normal voice but then both residents began to raise their voices. LVN C stated that at that point he stood up to intervene, but that Resident #2 moved toward Resident #1, grabbed him by the right arm of his sweater and hit Resident #1 in the face. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/22/2024 at 10:55 AM the Administrator revealed she was the Abuse Coordinator. She stated the argument between Resident #1 and #2 the morning of 02/26/24 in which Resident #2 stated to Resident #1 te [NAME] a partir la madre was not reported to her. The Administrator stated she believed the phrase meant I am going to kick your ass but that whether it should have been reported to her depended on LVN C's understanding of the phrase. She stated that the incident the morning of 02/26/2024 was not investigated. When asked if Resident #1 and Resident #2 were protected from each other at lunch time on 02/26/2024 she said she did not have an exact impression of what took place. She said, We are told to investigate abuse to determine root cause, how can we put a plan in place to maintain safety for all parties involved. Record review of the facility Abuse/Neglect revised 03/29/2018 revealed that the resident has the right to be free from abuse. Residents should not be subjected to abuse from anyone, including other residents. The facility will provide and ensure the protection of resident rights. It is each individual's responsibility to recognize and report actual or alleged abuse and situations that may constitute abuse of any resident in the facility. Verbal abuse examples include threats of harm. The facility will identify and investigate events that my constitute abuse/neglect. The facility will take necessary measures to protect residents from harm during and following an abuse investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675106	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Pointe Wellness Center	2301 N Oregon St El Paso, TX 79902

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34486 Based on observations, interview and record review the facility failed to ensure that a resident who displays or was diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one resident (Resident #1) of 3 reviewed for appropriate treatment and services to attain or maintain their highest practicable well-being. 1. The facility failed to track resident's ongoing wandering behaviors which placed him at risk of not having these behaviors identified and addressed. 2. The facility failed to identify and establish a care plan to address Resident #1's wandering behavior which placed him at risk of verbal and physical abuse from other residents. This failure puts residents with dementia at increased risk of not having their dementia-related needs met. Findings included: Record review of Resident #1's Face Sheet dated 03/21/2024 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Record review of Resident #1's History and Physical dated 04/08/2023 revealed he had been in the hospital for aggressive behavior. He had diagnoses including dementia, anxiety, major depressive disorder and delusional disorder. Record review of Resident #1's Physicians Progress Note dated 02/20/2024 revealed the resident continued to be confused and was oriented only to himself. Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 4 (severe cognitive impairment). Face Sheet dated revealed he had symptoms of delirium including intermittent inattention and disorganized thinking. He had no indicators of psychosis (disconnection from reality). He had verbal behavioral symptoms directed toward others 1-3 days of the 7-day look-back period. He had no impairment to his upper or lower body and used a walker or a wheelchair to move around the facility. He required moderate assistance for moving between surfaces and for walking. Record review of Resident #1's care plan revealed that on 03/12/2024 it was identified that he was at risk for wandering due to dementia. The goal was that he would not leave the facility unattended. Interventions included to distract him by offering pleasant diversion and if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. His care plan revised on 02/19/2024 documented he had cognitive impairment evidenced by a diagnosis of dementia, impaired Ability to Make decisions, risk for Impaired Communication, Difficulty Expressing Needs, Episodes of Disorganized thinking, Episodes of Inattention, and Impaired Safety Awareness. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes dated 12/9/2023 at 9:11 PM revealed the resident was pacing/ wandering in the hallway anxious and refused a shower. Record review of Resident #1's progress notes dated 12/10/2023 at 9:39 PM revealed the resident was pacing/ wandering in the hallway anxious, looking for the door. Stated Oiga ya me tengo que ir donde esta la [NAME], el tractor esta afuera (Listen, I have to go now. Where is the door? The tractor/truck is outside). Attempts at redirection were unsuccessful. Record review of Resident #1's progress notes dated 01/13/2024 at 11:50 AM revealed the resident was very anxious, pacing and entering other resident rooms, verbally aggressive to staff, using vulgar language. Attempts at redirection were unsuccessful. Record review of Resident #1's progress notes dated 2/25/2024 at 1:19 PM revealed the resident was in a wheelchair wandering in the hallway. He was placed in bed several times as per his request but kept trying to get back out of bed so was put back in the wheelchair because he was at risk for falling. Record review of a Progress Note written by LVN C dated 2/26/2024 at 09:29 AM revealed that Resident #1 was wheeling himself down the hall and entered another resident's room where another resident began to yell threats at Resident #1. In observation and interview on 3/19/2024 at 9:25 AM Resident #1 was found standing in the doorway to his room. When Surveyor D asked about bruises and falling the resident displayed symptoms of agitation (based on raising voice, clenching fists and bending arms at elbows) three times during the brief conversation. He was redirected and calmed down each time he began to become anxious. In an interview on 03/22/2024 at 4:04 PM LVN E stated that Resident #1 had some days on which he wandered. The LVN was unable to state how often this happened but said that the behaviors were ongoing. Record review of Resident #1's December 2023 MAR/TAR showed no orders for tracking wandering or other behaviors. Record review of Resident #1's January 2024 MAR/TAR showed no orders for tracking wandering or other behaviors. Record review of Resident #1's February 2024 MAR/TAR showed no orders for tracking wandering or other behaviors. Record review of Resident #1's March 2024 MAR/TAR showed an order for behavior monitoring including pacing was started on 03/19 2024 and discontinued 03/20/2024. An active order for behavior monitoring including pacing/wandering was started 03/20/2024. Behaviors documented between 03/20/2024 and 3/31/2024 included verbal behaviors once refused care once and inattention once. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/22/2024 at 5:34 PM the DON revealed that the addition to Resident #1's care plans of one for wandering was triggered by the resident having gone into another resident's room. She stated that it was important that residents' care plans be accurate. The DON said the resident had been going through a change in relation to wandering. She said that if staff had seen him going into another resident's room it would be on weekly nursing summaries and that would have triggered consideration for the care plan or monitoring behaviors. The DON said that Resident #1 walked but that it was not wandering, that it was an activity. She said that wandering or walking would be a problem if the resident had exit seeking behavior. She stated that Resident #1 did not have wandering behavior that had been assessed by nurse. She said if wandering was a behavior that had been identified then it should have been on the care plan. Record review of the facility policy Dementia Policy (undated) documented that behaviors in persons with dementia often represent that person's attempt to communicate an unmet need that they can no longer articulate. Knowledge of the resident can help caregivers identify environmental or other triggers to prevent or reduce behaviors or other expressions of distress. The facility's approach to care for a resident with dementia is expected to follow a systematic process to gather and analyze information necessary to provide appropriate care and services and includes development of a care plan that identifies approaches and interventions for the specific resident.