

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Grace Pointe Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 7 residents (Residents #1) reviewed for abuse.</p> <p>The facility failed to ensure residents right to be free from abuse when Resident #1 reported sexual abuse by CNA O to staff in January 2025 and the alleged perpetrator was not suspended, the allegation was not investigated, and the facility did not report the suspected crime to local law enforcement and the State Agency, resulting in failure to protect residents from further potential criminal activity by an alleged perpetrator.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 04/09/25. While the IJ was removed on 04/10/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at risk for further abuse, physical harm, psychosocial harm, trauma, unrecognized abuse, and emotional distress.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/09/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes), hypertension (high blood pressure), hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (lack oxygen to the brain causing damage to brain tissue) affecting left non-dominant side, and lack of coordination.</p> <p>Record review of Resident 1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment. Section GG - Functional Abilities revealed Resident #1 required substantiated/maximal assistance with toileting hygiene and shower/bathing.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Care Plan, dated 04/09/2025, revealed a focus area which reflected Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Bathing requires staff x1 for assistance.</p> <p>During an interview on 04/09/2025 at 10:44 a.m., Resident #1 said back on a day in January 2025, CNA O took him to a shower and while bathing the resident, CNA O stuck his finger inside Resident #1's anus once for about a second. Resident #1 said there were no other witnesses at the time of the incident. Resident #1 said he did not initially report the incident to anyone because he was embarrassed. Resident #1 said he was not injured or in any discomfort after the incident occurred. Resident #1 said he reported it to facility staff a few days later but could not remember who. Resident #1 said the facility did not do anything about what he reported because CNA O was still working at the facility although had not given Resident #1 any more showers. Resident #1 said he did not remember talking to any administrator or anyone else about what he reported. Resident #1 said this made him upset because he would not want another resident to go through what he went through. Resident #1 said CNA O did not work with him anymore after the incident.</p> <p>During an interview on 04/09/2025 at 12:22 p.m., CNA N said about two-three months ago, Resident #1 said he had been sexually abused by CNA O. CNA N said Resident #1 told another staff member during another shift about the allegation and CNA N believed the staff reported it to administration. CNA N said he did not report the allegation to anyone else because he thought it had already been reported. CNA N said he believed it was the Administrator who told staff males could not go into the room, and if they must go into Resident #1's room it needed to be with another staff. CNA N said CNA O was not suspended and stayed working on the floor with other residents. CNA N said no other residents complained about CNA O. CNA N said he did not know if anything was done about the allegation.</p> <p>During an interview on 04/09/2025 at 2:25 p.m., LVN H said Resident #1 refused to have males work with him. LVN H said Resident #1 just said to her he did not like one specific male CNA (CNA O) and was okay with the other male CNAs. LVN H said she did not know why Resident #1 did not want CNA O to work with him.</p> <p>During an interview on 04/09/2025 at 2:33 p.m., CNA P said she heard from other staff that a male was not supposed to take care of Resident #1. CNA P said she did not know why. CNA P said she did not know if the information was documented anywhere.</p> <p>During an interview on 04/09/2025 at 2:49 p.m., LVN F said one day about 3 or 4 months ago, CMA M informed LVN F Resident #1 was complaining about being sexually molested. LVN F said he talked with Resident #1 and the resident told him he felt he was sexually molested by inappropriate touching by a staff member. LVN F said Resident #1 did not say which staff at the time. LVN F said Resident #1 said he did not want any males working with him. LVN F said he reported the allegation to ADON E. LVN F said he believed ADON E reported it to the Administrator. LVN F said ADON E told him to make sure no males went into the room with Resident #1. LVN F said he then informed the staff on the floor about the instructions ADON E told him regarding no males in Resident #1's room. LVN F said the allegation was reported by Resident #1 days after the alleged incident occurred. LVN F said Resident #1 did not complain about any discomfort or injury. LVN F said he did not remember if he documented the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 3:37 p.m., the ADON E said all allegations reported needed to be reported to the Administrator or the DON right away. The ADON E said she had the DON and Administrator's numbers and they were on-call 24/7. The ADON E said one evening several months back, LVN F said Resident #1 felt he was abused two to three days before when he was getting showered and while staff cleaned his buttocks, Resident #1 felt CNA O touched him inappropriately. The ADON E said he asked LVN F to write him a statement. ADON E learned Resident #1 reported the allegation to CMA M, and she then reported it to LVN F. ADON E said he called the Administrator on the phone and told her there was an allegation of abuse in the building. ADON E could not recall the time he called the Administrator. ADON E said the Administrator told him she was out of the building, but when she came back, she would follow-up on the allegation. ADON E said he did not speak with Resident #1 and figured the Administrator would do what needed to be done such as report and investigate. ADON E said he had been trained to report allegations of abuse/neglect/exploitation to the Administrator immediately. The ADON E said he instructed LVN F no males were allowed in Resident #1's room. ADON E said Resident #1 was informed and he did not have a problem with any other male CNAs, and only CNA O. ADON E said he told LVN F to document the incident on the 24-hour report. ADON E said nothing was brought up in the morning meeting the following day. ADON E said he did not document any of the events anywhere. ADON E said the written statement by LVN F was given to the Administrator and he did not know what the Administrator did then.</p> <p>During an interview on 04/09/2025 at 4:19 p.m., CMA M said she was trained to report allegations of abuse, to include sexual abuse, to the charge nurse and Administrator immediately. CMA M said several months ago, Resident #1 reported to her he did not want CNA O in his room. CMA M said Resident #1 said an incident occurred 2 to 3 days before. CMA M said Resident #1 said while CNA O was assisting him to shower, CNA O touched Resident #1 inappropriately on his backside. CMA M said Resident #1 did not complain of any pain at the time. CMA M said she told Resident #1 she would report it to the nurse, and the nurse would talk with him. CMA M said she told LVN F, but she did not contact the Administrator. CMA M said she knew she should have informed the Administrator but failed to do so since she told LVN F. CMA M said CNA O still worked at the facility but did not provide any patient care to Resident #1. CMA M said she heard no other complaints from any other residents regarding CNA O.</p> <p>During an interview on 04/09/2025 at 4:30 p.m., CNA O said he had been working at the facility for [AGE] years. CNA O said he had been trained on reporting abuse/neglect allegations immediately to the Administrator. CNA O said no residents complained to him about any abuse or inappropriate touching. CNA O said he had not been suspended for any incidents or allegations. CNA O said no resident had complained about him. CNA O said he was familiar with Resident #1 and the resident did not want any males in the room. CNA O said Resident #1 did not have any problems with him. CNA O said he was told by LVN F not to work with Resident #1 with no other explanation. CNA O denied any knowledge of any sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 5:05 p.m., the Administrator said her responsibility when it came to allegations of abuse, neglect, or exploitation was to protect the resident, gather information, and proceed with the investigation. The Administrator said she was also responsible to contact the State Survey Agency and if needed law enforcement. The Administrator said all allegations of abuse would be reported to the State Survey Agency within 2 hours. The Administrator said if there were any allegations of sexual abuse, the allegation would be reported to the State Survey Agency, law enforcement, and the physician and responsible parties. The Administrator said she had not received any reports of any type of sexual abuse. The Administrator said she was familiar with Resident #1, and he had not made any complaints with her. The Administrator denied being notified or having any knowledge of any alleged sexual abuse which involved Resident #1.</p> <p>Record review of Resident #1's Progress Notes from January 2025 to April 2025 did not reveal any documentation regarding the allegation of sexual abuse.</p> <p>Record review of Social Service Quarterly Assessment for Resident #1, dated 01/17/2025 at 4:00 p.m., read in part, Resident can have times when he becomes upset at staff but for the most part gets along well with everyone. At this time there are to be no male CNAs in resident's room.</p> <p>Record review of the 24-hour reports for the month of January 2025, did not reveal any information on the allegation of sexual abuse.</p> <p>Record review of TULIP revealed no prior self-reports related to the allegation of abuse which involved Resident #1 from 01/01/2025 to 04/09/2025.</p> <p>Record review of a copy of a statement written by CMA M, dated 1/14/2025, read To whom it may concern, On Wednesday, January 8th, [CMA M] reported to [LVN F] nurse in charge of [Resident #1] reporting an incident of sexual harassment. [Resident #1] stated that he was upset with [CNA O]. [Resident #1] said that [CNA O] inserted his fingers while [CNA O] was showering him. [CMA M] immediately reported to [LVN F].</p> <p>Record review of the facility provided Abuse/Neglect policy, with revision date 3/29/2018, read in part Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff . Prevention ., The facility will provide the residents, families, and staff an environment free from abuse and neglect. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy .Reporting, Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19; a) If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation Investigation .Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist.the employee(s) will immediately be suspended pending an investigation .Protection .The facility will take necessary measures to protect residents</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This was determined to be an Immediate Jeopardy (IJ) on 04/08/2025 at 8:00 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 04/08/2025 at 8:00 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 4/10/2025 at 1:40 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Abuse allegation investigations started on 4/9/2025 and are ongoing. Furthermore, as per policy, all new investigations start immediately upon receiving an allegation. - The resident was interviewed at the time of discovery on 4/9/2025 and could not recall exact details of the event due to diagnosis of vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to damage and cognitive decline). He does not recall in the same way today, but the general allegation remains the same. A trauma informed care assessment was completed by the DON on 4/9/2025. Results were no negative outcomes. - One on One in-service on Abuse Reporting with the Administrator, DON, by Area Director of Operation (ADO) on 4/9/2025 at 20:08. - One on One in-service on Investigating allegations with the Administrator, DON, by ADO on 4/10/2025 at 10:23am. - Staff working with alleged perpetrators have been interviewed by the Administrator, Director of Nursing, ADO, and Compliance Nurse. Statements revealed the medication aide was the first to learn of the concern, she reported to the charge nurse who reported to the ADON. The ADON reported he phoned the administrator and left copies of the statements with her. All interviews were completed on 4/9/2025. The resident is doing ok; no distress was noted, and the resident was able to voice concerns. - The alleged perpetrator was suspended on 4/9/2025 at 6:00 p.m., pending the outcome of the investigation. - The ADON was suspended on 4/9/2025 at 9:00 p.m., pending the outcome of the investigation. - Notification of Authorities: Law enforcement and HHSC were notified promptly in accordance with state-mandated reporting guidelines on 04/09/2025. - Emotional Support: Social services and/or a mental health provider were contacted to provide counseling and emotional support to the resident; referral was sent as on 04/09/2025. - All residents who were able to be interviewed had safety surveys on 4/9/2025 by the social worker. No abuse incidents were reported. All surveys were completed on 4/9/2025. - All residents who were able to be interviewed were interviewed by DON/Compliance Nurse/Social worker on 4/9/2025. A new skin assessment was completed on all non-verbal residents, by the same group was completed on 4/9/2025 with no abnormal findings (unknown bruises, skin tears, abrasions). <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The following in-services were initiated on 4/9/2025 by the Administrator/ADO: Any staff member not present or in-service on 4/9/2025 will not be allowed to assume their duties until in-service. These will be completed by 4/10/2025.</p> <p>- All Staff</p> <p>? Abuse/Neglect with special focus on sexual abuse</p> <p>? Abuse/Neglect Reporting</p> <p>? Who to Report Abuse/Neglect to Administrator and Director of Nursing</p> <p>Previously this was to be reported to only the administrator, but a second layer of reporting was added to prevent oversight of a single individual.</p> <p>- All in-serviced staff will need to be able to articulate back on reporting any abuse allegation and to whom to report by 4/10/2025</p> <p>-The administrator/designee will assess and monitor understanding by quizzing and providing examples on in-services beginning 4/9/2025.</p> <p>- New staff will be in service during orientation before assuming any duties.</p> <p>- The medical director was notified of the immediate jeopardy situation on 4/9/2025 at 8:23 p.m.</p> <p>- The administrator will report any abuse allegations, investigate, and submit findings to the Area Director and Risk Management for review. 4 weeks and PRN thereafter.</p> <p>-The administrator will submit documentation of the investigation with Resident and Staff interviews, as well as weekly follow-up interviews with staff and residents x 4 weeks to ensure resident safety/satisfaction with the outcome of the investigation.</p> <p>- The Area Director will monitor abuse allegations reported by residents and or staff and check the real-time system, which monitors keywords like abuse x 4 weeks' documentation and PCC for any incidents and accidents.</p> <p>- The QA committee will review the findings of abuse allegations and investigations monthly and make changes to the system as needed. 4 weeks until substantial compliance is achieved.</p> <p>Monitoring of the facility's plan of removal included the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/2025 at 1:50 p.m., the ADO stated an investigation into the allegation of sexual abuse was started on 04/09/2025 and continuing. The ADO said she in-serviced the DON and Administrator one-on-one regarding the reporting of abuse and investigating allegations. The ADO said all new investigations would start immediately upon receiving an allegation. The ADO said CNA O and ADON E were suspended pending the investigation. The ADO said a referral for emotional support was sent on 4/9/2025 to provide counseling and emotional support to Resident #1. The ADO said part of the plan included all new staff would be in-serviced during orientation. The ADO said the Administrator would submit documentation of the investigation and have weekly follow-up interviews with staff for 4 weeks to ensure resident safety. The ADO said she would monitor abuse allegations reported by residents and/or staff and check the real-time system for keywords like abuse for 4 weeks. The ADO said the QA committee would review findings of all abuse allegations and investigations monthly and make changes as needed.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., the DON stated an investigation into the allegation of sexual abuse started on 4/9/2025. The DON stated being in-serviced by ADO regarding new investigations would start immediately upon receiving an allegation. The DON said CNA O and ADON E were suspended pending investigation. The DON said residents who were able to be interviewed were interviewed and a skin assessment was completed on all non-verbal residents on 4/9/2025.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., the Administrator stated an investigation into the allegation of sexual abuse started on 4/9/2025 and CNA O and ADON E were suspended pending the investigation. The Administrator stated ADO in-serviced her on new investigations needing to start immediately upon receiving an allegation. The Administrator said staff working with the alleged perpetrator were interviewed on 4/9/2025. The Administrator said law enforcement was contacted on 4/9/2025. The Administrator said all facility staff, before assuming their duties, were in-serviced on abuse/neglect with focus on sexual abuse, abuse/neglect reporting, and who to report allegations of abuse/neglect to, being the Administrator and the DON.</p> <p>During an interview on 04/10/2025 at 2:01 p.m., CNA N who works the 6:00 a.m. to 2:00 p.m. shift, said he said he was in-serviced on abuse/neglect. CNA N said all allegations to include sexual abuse, needed to be reported to the DON and the Administrator immediately after ensuring resident were safe. CNA N was able to point out where to locate the contact number posting.</p> <p>During an interview on 04/10/2025 at 2:03 p.m., LVN J who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN J said all allegations of abuse/neglect to include sexual abuse were to be reported to the Abuse Coordinator/Administrator and DON immediately as soon as verifying the resident was safe. LVN J was able to point out where to locate the posted contact numbers for the Administrator and DON.</p> <p>During an interview on 4/10/2025 at 2:04 p.m., LVN K who works the 6:00 a.m. to 2:00 p.m., shift, said she was in-serviced on abuse/neglect and reporting. LVN K said when it came to abuse/neglect, she must make sure the resident was safe from any abuse and then immediately report the allegation to the DON and Administrator/Abuse Coordinator. LVN K was able to point out where to find the posted contact numbers for the Administrator and DON.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 2:05 p.m., LVN G who works 6:00 a.m. to 2:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN G said all allegations of abuse/neglect which included sexual abuse must be reported immediately to the Abuse Coordinator and the DON. LVN G was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>During an interview on 4/10/2025 at 2:06 p.m., CNA S who works 10:00 p.m. to 6:00 a.m. shift, said she was in-serviced on abuse/neglect reporting. CNA S said for all allegations of abuse/neglect which included sexual abuse, it should be reported immediately to Abuse Coordinator and DON after seeing the resident was safe. CNA S was able to point out where to locate the contact numbers for the DON and the Administrator.</p> <p>During an interview on 4/10/2025 at 2:09 p.m., LVN F who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN F said he was responsible to protect residents and make sure they were safe and then report all allegations to the Abuse Coordinator/Administrator and the DON immediately. LVN F was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., CNA T who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. CNA T said she needed to make sure residents were safe and then report it right away to the Administrator and the DON. CNA T was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:11 p.m., LVN H who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. LVN H said when it came to allegations of abuse/neglect, first make sure the resident was safe, and then call the Administrator/Abuse Coordinator and the DON immediately as soon as possible. LVN H was able to point out where the posted contact numbers for the DON and Administrator were located.</p> <p>During an interview on 4/10/2025 at 2:18 p.m., CNA R said she was in-serviced on reporting abuse/neglect allegations. CNA R said it was the staff responsibility to make sure the resident was safe and then immediately report to the Administrator/Abuse Coordinator and the DON. CNA R was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:20 p.m., HK Z said she was in-serviced on reporting abuse/neglect. The HK staff said her responsibility was to report any allegations of abuse/neglect to the Abuse Coordinator and the DON immediately. The HK was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>During an interview on 4/10/2025 at 2:23 p.m., LVN L who works multiple shift times from 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m., said he was in-serviced on abuse/neglect reporting. LVN L said his responsibility was to keep the residents safe and remove the alleged perpetrator if with the resident. LVN L said he then called the Administrator/Abuse Coordinator and the DON immediately to report the allegation. LVN L was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., MA Y said she was in-serviced on reporting abuse/neglect. MA Y said allegations of abuse/neglect which included sexual abuse needed to be reported immediately to the Abuse Coordinator and the DON after making sure the resident was safe. MA Y was able to point out where to locate contact number.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 2:26 p.m., LVN I who works the 2:00 p.m. to 10:00 p.m. shift, said she received training on abuse/neglect reporting. LVN I said she was responsible to make sure residents were safe and call the Administrator and the DON to report immediately. LVN I was able to point out where the contact numbers of the Administrator and the DON were posted.</p> <p>During an interview on 4/10/2025 at 2:31 p.m., CNA U said she was in-serviced on reporting abuse/neglect. CNA U said she was trained to make sure residents were safe and report allegations of abuse/neglect, to include sexual abuse, to the Abuse Coordinator and the DON immediately.</p> <p>During an interview on 4/10/2025 at 2:35 p.m., the Activity Director said she was trained on reporting abuse/neglect. The Activity Director said for allegations of abuse/neglect, she would report immediately to the Abuse Coordinator/Administrator and the DON. The Activity Director pointed out where the contact numbers were for the DON and Administrator were located.</p> <p>During an interview on 4/10/2025 at 2:38 p.m., Dietary Staff W said she was trained on reporting abuse/neglect. Dietary Staff W said if she suspected or witnessed any abuse/neglect, she would make sure the resident was safe and then report it to the Abuse Coordinator/Administrator and the DON immediately.</p> <p>Record review of the Facility's In-Service training records titled Self-Reporting Protocol/Ad Hoc QAPI dated 4/9/2025, revealed allegation reported to the State; alleged perpetrator suspended; resident interviewed; interview of resident roommate; interviews with interviewable residents regarding staff treatment; skin assessment for residents who are unable to be interviewed; interview of staff regarding if they observed any potential abuse; performed a Trauma Informed PRN Assessment; notification to law enforcement; notification of medical director; were conducted and signed by the Administrator and the DON.</p> <p>Record review of the facility's document titled In-Service Training Attendance Roster, dated 4/9/2025, reflected that ADO conducted one-on-one in-services with the Administrator and the DON on training topic of allegation reporting guidelines.</p> <p>Record review of the facility's documentation regarding investigating allegations, revealed witness statements were taken on 04/09/2025 related to the allegation of sexual abuse, from Resident #1, the DON, ADON E and the Administrator.</p> <p>Record review of the Facility's In-Service Training records revealed training was conducted on 4/10/2025. The in-services were, dated 4/9/2025 and 4/10/2025, and included the topics of abuse/neglect/exploitation, abuse/neglect reporting, and who to report allegations of abuse/neglect to. Seventy-eight (78) out of (81) staff had signed the in-service training forms.</p> <p>Record review of Employee Disciplinary Reports, dated 04/09/2025, revealed CNA O and ADON E were placed on suspension pending investigation.</p> <p>Record review of the Police Department Incident Information Card, dated 4/9/2025, revealed a police report was made .</p> <p>Record review of Order, dated 4/10/2025, revealed an order for Resident #1 for counseling and emotional support services.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Trauma Informed PRN Assessment, dated 04/09/2025, revealed the assessment was completed for Resident #1 by the DON.</p> <p>Record review of Resident Safe Surveys, dated 4/9/2025, reflected 45 resident surveys were conducted. The document covered the areas of 1) had anyone physically harmed the resident, if yes provide details; 2) has staff yelled or cursed at you; 3) does the resident feel comfortable asking staff for assistance; and 4) does staff treat you with respect. No potential abuse was noted.</p> <p>Record review of Resident Skin Assessments, dated 4/9/2025, reflected 17 assessments were performed for non-verbal residents with no abnormal findings.</p> <p>The ADO and Administrator were informed that the IJ was removed on 04/10/2025 at 4:46 a.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures for 1 of 7 residents (Resident #2) reviewed for abuse.</p> <p>-The Facility Administrator failed to report a suspected crime to local law enforcement and the State Survey Agency, resulting in failure to protect residents from further potential criminal activity by an alleged perpetrator when Resident #1 reported sexual abuse by CNA O to staff in January 2025.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 04/09/25. While the IJ was removed on 04/10/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for abuse, physical harm, psychosocial harm, trauma, unrecognized abuse, and emotional distress.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/09/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes), hypertension (high blood pressure), hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (lack oxygen to the brain causing damage to brain tissue) affecting left non-dominant side, and lack of coordination.</p> <p>Record review of Resident 1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment. Section GG - Functional Abilities revealed Resident #1 required substantiated/maximal assistance with toileting hygiene and shower/bathing.</p> <p>Record review of Resident #1's Care Plan, dated 04/09/2025, revealed a focus area which reflected Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Bathing requires staff x1 for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 10:44 a.m., Resident #1 said back on a day in January 2025, CNA O took him to a shower and while bathing the resident, CNA O stuck his finger inside Resident #1's anus once for about a second. Resident #1 said there were no other witnesses at the time of the incident. Resident #1 said he did not initially report the incident to anyone because he was embarrassed. Resident #1 said he was not injured or in any discomfort after the incident occurred. Resident #1 said he reported it to facility staff a few days later but could not remember who. Resident #1 said the facility did not do anything about what he reported because CNA O was still working at the facility although had not given Resident #1 any more showers. Resident #1 said he did not remember talking to any administrator or anyone else about what he reported. Resident #1 said this made him upset because he would not want another resident to go through what he went through. Resident #1 said CNA O did not work with him anymore after the incident.</p> <p>During an interview on 04/09/2025 at 12:22 p.m., CNA N said about two-three months ago, Resident #1 said he had been sexually abused by CNA O. CNA N said Resident #1 told another staff member during another shift about the allegation and CNA N believed the staff reported it to administration. CNA N said he did not report the allegation to anyone else because he thought it had already been reported. CNA N said he believed it was the Administrator who told staff males could not go into the room, and if they must go into Resident #1's room it needed to be with another staff. CNA N said CNA O was not suspended and stayed working on the floor with other residents. CNA N said no other residents complained about CNA O. CNA N said he did not know if anything was done about the allegation.</p> <p>During an interview on 04/09/2025 at 2:25 p.m., LVN H said Resident #1 refused to have males work with him. LVN H said Resident #1 just said to her he did not like one specific male CNA (CNA O) and was okay with the other male CNAs. LVN H said she did not know why Resident #1 did not want CNA O to work with him.</p> <p>During an interview on 04/09/2025 at 2:33 p.m., CNA P said she heard from other staff that a male was not supposed to take care of Resident #1. CNA P said she did not know why. CNA P said she did not know if the information was documented anywhere.</p> <p>During an interview on 04/09/2025 at 2:49 p.m., LVN F said one day about 3 or 4 months ago, CMA M informed LVN F Resident #1 was complaining about being sexually molested. LVN F said he talked with Resident #1 and the resident told him he felt he was sexually molested by inappropriate touching by a staff member. LVN F said he reported the allegation to ADON E. LVN F said he believed ADON E reported it to the Administrator. LVN F said the allegation was reported by Resident #1 days after the alleged incident occurred. LVN F said he did not remember if he documented the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 3:37 p.m., the ADON E said all allegations reported needed to be reported to the Administrator or the DON right away. The ADON E said she had the DON and Administrator's numbers, and they were on-call 24/7. The ADON E said one evening several months back, LVN F said Resident #1 felt he was abused two to three days before when he was getting showered and while staff cleaned his buttocks, Resident #1 felt CNA O touched him inappropriately. The ADON E said he asked LVN F to write him a statement. ADON E learned Resident #1 reported the allegation to CMA M, and she then reported it to LVN F. ADON E said he called the Administrator on the phone and told her there was an allegation of abuse in the building. ADON E could not recall the time he called the Administrator. ADON E said the Administrator told him she was out of the building, but when she came back, she would follow-up on the allegation. ADON E said he had been trained to report allegations of abuse/neglect/exploitation to the Administrator immediately. ADON E said he told LVN F to document the incident on the 24-hour report. ADON E said the written statement by LVN F was given to the Administrator and he did not know what the Administrator did then.</p> <p>During an interview on 04/09/2025 at 4:19 p.m., CMA M said she was trained to report allegations of abuse, to include sexual abuse, to the charge nurse and Administrator immediately. CMA M said several months ago, Resident #1 reported to her he did not want CNA O in his room. CMA M said Resident #1 said an incident occurred 2 to 3 days before. CMA M said Resident #1 said while CNA O was assisting him to shower, CNA O touched Resident #1 inappropriately on his backside. CMA M said Resident #1 did not complain of any pain at the time. CMA M said she told Resident #1 she would report it to the nurse, and the nurse would talk with him. CMA M said she told LVN F, but she did not contact the Administrator. CMA M said she knew she should have informed the Administrator but failed to do so since she told LVN F. CMA M said CNA O still worked at the facility but did not provide any patient care to Resident #1. CMA M said she heard no other complaints from any other residents regarding CNA O.</p> <p>During an interview on 04/09/2025 at 4:30 p.m., CNA O said he had been working at the facility for [AGE] years. CNA O said he had been trained on reporting abuse/neglect allegations immediately to the Administrator. CNA O said no residents complained to him about any abuse or inappropriate touching. CNA O said he had not been suspended for any incidents or allegations. CNA O said no resident had complained about him. CNA O said he was familiar with Resident #1 and the resident did not want any males in the room. CNA O said Resident #1 did not have any problems with him. CNA O said he was told by LVN F not to work with Resident #1 with no other explanation. CNA O denied any knowledge of any sexual abuse.</p> <p>During an interview on 04/09/2025 at 5:05 p.m., the Administrator said her responsibility when it came to allegations of abuse, neglect, or exploitation was to protect the resident, gather information, and proceed with the investigation. The Administrator said she was also responsible to contact the State Survey Agency and if needed law enforcement. The Administrator said all allegations of abuse would be reported to the State Survey Agency within 2 hours. The Administrator said if there were any allegations of sexual abuse, the allegation would be reported to the State Survey Agency, law enforcement, and the physician and responsible parties. The Administrator said she had not received any reports of any type of sexual abuse. The Administrator said she was familiar with Resident #1, and he had not made any complaints with her. The Administrator denied being notified or having any knowledge of any alleged sexual abuse which involved Resident #1.</p> <p>Record review of Resident #1's Progress Notes from January 2025 to April 2025 did not reveal any documentation regarding the allegation of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Social Service Quarterly Assessment for Resident #1, dated 01/17/2025 at 4:00 p.m., read in part, Resident can have times when he becomes upset at staff but for the most part gets along well with everyone. At this time there are to be no male CNAs in resident's room.</p> <p>Record review of the 24-hour reports for the month of January 2025, did not reveal any information on the allegation of sexual abuse.</p> <p>Record review of TULIP revealed no prior self-reports related to the allegation of abuse which involved Resident #1 from 01/01/2025 to 04/09/2025.</p> <p>Record review of a copy of a statement written by CMA M, dated 1/14/2025, read To whom it may concern, On Wednesday, January 8th, [CMA M] reported to [LVN F] nurse in charge of [Resident #1] reporting an incident of sexual harassment. [Resident #1] stated that he was upset with [CNA O]. [Resident #1] said that [CNA O] inserted his fingers while [CNA O] was showering him. [CMA M] immediately reported to [LVN F].</p> <p>Record review of the facility provided Abuse/Neglect policy, with revision date 3/29/2018, read in part All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Appropriate notification to state and home office will be the responsibility of the administrator and per policy .Reporting: Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19; a) If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation Investigation .Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 04/08/2025 at 8:00 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 04/08/2025 at 8:00 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 4/10/2025 at 1:40 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Abuse allegation investigations started on 4/9/2025 and are ongoing. Furthermore, as per policy, all new investigations start immediately upon receiving an allegation. - The resident was interviewed at the time of discovery on 4/9/2025 and could not recall exact details of the event due to diagnosis of vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to damage and cognitive decline). He does not recall in the same way today, but the general allegation remains the same. A trauma informed care assessment was completed by the DON on 4/9/2025. Results were no negative outcomes. - One on One in-service on Abuse Reporting with the Administrator, DON, by Area Director of Operation (ADO) on 4/9/2025 at 20:08. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- One on One in-service on Investigating allegations with the Administrator, DON, by ADO on 4/10/2025 at 10:23am.</p> <p>- Staff working with alleged perpetrators have been interviewed by the Administrator, Director of Nursing, ADO, and Compliance Nurse. Statements revealed the medication aide was the first to learn of the concern, she reported to the charge nurse who reported to the ADON. The ADON reported he phoned the administrator and left copies of the statements with her. All interviews were completed on 4/9/2025. The resident is doing ok; no distress was noted, and the resident was able to voice concerns.</p> <p>- The alleged perpetrator was suspended on 4/9/2025 at 6:00 p.m., pending the outcome of the investigation.</p> <p>- The ADON was suspended on 4/9/2025 at 9:00 p.m., pending the outcome of the investigation.</p> <p>- Notification of Authorities: Law enforcement and HHSC were notified promptly in accordance with state-mandated reporting guidelines on 04/09/2025.</p> <p>- Emotional Support: Social services and/or a mental health provider were contacted to provide counseling and emotional support to the resident; referral was sent as on 04/09/2025.</p> <p>- All residents who were able to be interviewed had safety surveys on 4/9/2025 by the social worker. No abuse incidents were reported. All surveys were completed on 4/9/2025.</p> <p>- All residents who were able to be interviewed were interviewed by DON/Compliance Nurse/Social worker on 4/9/2025. A new skin assessment was completed on all non-verbal residents, by the same group was completed on 4/9/2025 with no abnormal findings (unknown bruises, skin tears, abrasions).</p> <p>-The following in-services were initiated on 4/9/2025 by the Administrator/ADO: Any staff member not present or in-service on 4/9/2025 will not be allowed to assume their duties until in-service. These will be completed by 4/10/2025.</p> <p>- All Staff</p> <p>? Abuse/Neglect with special focus on sexual abuse</p> <p>? Abuse/Neglect Reporting</p> <p>? Who to Report Abuse/Neglect to Administrator and Director of Nursing</p> <p>Previously this was to be reported to only the administrator, but a second layer of reporting was added to prevent oversight of a single individual.</p> <p>- All in-serviced staff will need to be able to articulate back on reporting any abuse allegation and to whom to report by 4/10/2025</p> <p>-The administrator/designee will assess and monitor understanding by quizzing and providing examples on in-services beginning 4/9/2025.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - New staff will be in service during orientation before assuming any duties. - The medical director was notified of the immediate jeopardy situation on 4/9/2025 at 8:23 p.m. - The administrator will report any abuse allegations, investigate, and submit findings to the Area Director and Risk Management for review. 4 weeks and PRN thereafter. -The administrator will submit documentation of the investigation with Resident and Staff interviews, as well as weekly follow-up interviews with staff and residents x 4 weeks to ensure resident safety/satisfaction with the outcome of the investigation. - The Area Director will monitor abuse allegations reported by residents and or staff and check the real-time system, which monitors keywords like abuse x 4 weeks' documentation and PCC for any incidents and accidents. - The QA committee will review the findings of abuse allegations and investigations monthly and make changes to the system as needed. 4 weeks until substantial compliance is achieved. <p>Monitoring of the facility's plan of removal included the following:</p> <p>During an interview on 04/10/2025 at 1:50 p.m., the ADO stated an investigation into the allegation of sexual abuse was started on 04/09/2025 and continuing. The ADO said she in-serviced the DON and Administrator one-on-one regarding the reporting of abuse and investigating allegations. The ADO said all new investigations would start immediately upon receiving an allegation. The ADO said CNA O and ADON E were suspended pending the investigation. The ADO said a referral for emotional support was sent on 4/9/2025 to provide counseling and emotional support to Resident #1. The ADO said part of the plan included all new staff would be in-serviced during orientation. The ADO said the Administrator would submit documentation of the investigation and have weekly follow-up interviews with staff for 4 weeks to ensure resident safety. The ADO said she would monitor abuse allegations reported by residents and/or staff and check the real-time system for keywords like abuse for 4 weeks. The ADO said the QA committee would review findings of all abuse allegations and investigations monthly and make changes as needed.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., the DON stated an investigation into the allegation of sexual abuse started on 4/9/2025. The DON stated being in-serviced by ADO regarding new investigations would start immediately upon receiving an allegation. The DON said CNA O and ADON E were suspended pending investigation. The DON said residents who were able to be interviewed were interviewed and a skin assessment was completed on all non-verbal residents on 4/9/2025.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., the Administrator stated an investigation into the allegation of sexual abuse started on 4/9/2025 and CNA O and ADON E were suspended pending the investigation. The Administrator stated ADO in-serviced her on new investigations needing to start immediately upon receiving an allegation. The Administrator said staff working with the alleged perpetrator were interviewed on 4/9/2025. The Administrator said law enforcement was contacted on 4/9/2025. The Administrator said all facility staff, before assuming their duties, were in-serviced on abuse/neglect with focus on sexual abuse, abuse/neglect reporting, and who to report allegations of abuse/neglect to, being the Administrator and the DON.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Grace Pointe Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 N Oregon St El Paso, TX 79902	
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/2025 at 2:01 p.m., CNA N who works the 6:00 a.m. to 2:00 p.m. shift, said he said he was in-serviced on abuse/neglect. CNA N said all allegations to include sexual abuse, needed to be reported to the DON and the Administrator immediately after ensuring resident were safe. CNA N was able to point out where to locate the contact number posting.</p> <p>During an interview on 04/10/2025 at 2:03 p.m., LVN J who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN J said all allegations of abuse/neglect to include sexual abuse were to be reported to the Abuse Coordinator/Administrator and DON immediately as soon as verifying the resident was safe. LVN J was able to point out where to locate the posted contact numbers for the Administrator and DON.</p> <p>During an interview on 4/10/2025 at 2:04 p.m., LVN K who works the 6:00 a.m. to 2:00 p.m., shift, said she was in-serviced on abuse/neglect and reporting. LVN K said when it came to abuse/neglect, she must make sure the resident was safe from any abuse and then immediately report the allegation to the DON and Administrator/Abuse Coordinator. LVN K was able to point out where to find the posted contact numbers for the Administrator and DON.</p> <p>During an interview on 4/10/2025 at 2:05 p.m., LVN G who works 6:00 a.m. to 2:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN G said all allegations of abuse/neglect which included sexual abuse must be reported immediately to the Abuse Coordinator and the DON. LVN G was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>During an interview on 4/10/2025 at 2:06 p.m., CNA S who works 10:00 p.m. to 6:00 a.m. shift, said she was in-serviced on abuse/neglect reporting. CNA S said for all allegations of abuse/neglect which included sexual abuse, it should be reported immediately to Abuse Coordinator and DON after seeing the resident was safe. CNA S was able to point out where to locate the contact numbers for the DON and the Administrator.</p> <p>During an interview on 4/10/2025 at 2:09 p.m., LVN F who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN F said he was responsible to protect residents and make sure they were safe and then report all allegations to the Abuse Coordinator/Administrator and the DON immediately. LVN F was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., CNA T who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. CNA T said she needed to make sure residents were safe and then report it right away to the Administrator and the DON. CNA T was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:11 p.m., LVN H who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. LVN H said when it came to allegations of abuse/neglect, first make sure the resident was safe, and then call the Administrator/Abuse Coordinator and the DON immediately as soon as possible. LVN H was able to point out where the posted contact numbers for the DON and Administrator were located.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 2:18 p.m., CNA R said she was in-serviced on reporting abuse/neglect allegations. CNA R said it was the staff responsibility to make sure the resident was safe and then immediately report to the Administrator/Abuse Coordinator and the DON. CNA R was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:20 p.m., HK Z said she was in-serviced on reporting abuse/neglect. The HK staff said her responsibility was to report any allegations of abuse/neglect to the Abuse Coordinator and the DON immediately. The HK was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>During an interview on 4/10/2025 at 2:23 p.m., LVN L who works multiple shift times from 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m., said he was in-serviced on abuse/neglect reporting. LVN L said his responsibility was to keep the residents safe and remove the alleged perpetrator if with the resident. LVN L said he then called the Administrator/Abuse Coordinator and the DON immediately to report the allegation. LVN L was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., MA Y said she was in-serviced on reporting abuse/neglect. MA Y said allegations of abuse/neglect which included sexual abuse needed to be reported immediately to the Abuse Coordinator and the DON after making sure the resident was safe. MA Y was able to point out where to locate contact number.</p> <p>During an interview on 4/10/2025 at 2:26 p.m., LVN I who works the 2:00 p.m. to 10:00 p.m. shift, said she received training on abuse/neglect reporting. LVN I said she was responsible to make sure residents were safe and call the Administrator and the DON to report immediately. LVN I was able to point out where the contact numbers of the Administrator and the DON were posted.</p> <p>During an interview on 4/10/2025 at 2:31 p.m., CNA U said she was in-serviced on reporting abuse/neglect. CNA U said she was trained to make sure residents were safe and report allegations of abuse/neglect, to include sexual abuse, to the Abuse Coordinator and the DON immediately.</p> <p>During an interview on 4/10/2025 at 2:35 p.m., the Activity Director said she was trained on reporting abuse/neglect. The Activity Director said for allegations of abuse/neglect, she would report immediately to the Abuse Coordinator/Administrator and the DON. The Activity Director pointed out where the contact numbers were for the DON and Administrator were located.</p> <p>During an interview on 4/10/2025 at 2:38 p.m., Dietary Staff W said she was trained on reporting abuse/neglect. Dietary Staff W said if she suspected or witnessed any abuse/neglect, she would make sure the resident was safe and then report it to the Abuse Coordinator/Administrator and the DON immediately.</p> <p>Record review of the Facility's In-Service training records titled Self-Reporting Protocol/Ad Hoc QAPI dated 4/9/2025, revealed allegation reported to the State; alleged perpetrator suspended; resident interviewed; interview of resident roommate; interviews with interviewable residents regarding staff treatment; skin assessment for residents who are unable to be interviewed; interview of staff regarding if they observed any potential abuse; performed a Trauma Informed PRN Assessment; notification to law enforcement; notification of medical director; were conducted and signed by the Administrator and the DON.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's document titled In-Service Training Attendance Roster, dated 4/9/2025, reflected that ADO conducted one-on-one in-services with the Administrator and the DON on training topic of allegation reporting guidelines.</p> <p>Record review of the facility's documentation regarding investigating allegations, revealed witness statements were taken on 04/09/2025 related to the allegation of sexual abuse, from Resident #1, the DON, ADON E and the Administrator.</p> <p>Record review of the Facility's In-Service Training records revealed training was conducted on 4/10/2025. The in-services were, dated 4/9/2025 and 4/10/2025, and included the topics of abuse/neglect/exploitation, abuse/neglect reporting, and who to report allegations of abuse/neglect to. Seventy-eight (78) out of (81) staff had signed the in-service training forms.</p> <p>Record review of Employee Disciplinary Reports, dated 04/09/2025, revealed CNA O and ADON E were placed on suspension pending investigation.</p> <p>Record review of the Police Department Incident Information Card, dated 4/9/2025, revealed a police report was made.</p> <p>Record review of Order, dated 4/10/2025, revealed an order for Resident #1 for counseling and emotional support services.</p> <p>Record review of Trauma Informed PRN Assessment, dated 04/09/2025, revealed the assessment was completed for Resident #1 by the DON.</p> <p>Record review of Resident Safe Surveys, dated 4/9/2025, reflected 45 resident surveys were conducted. The document covered the areas of 1) had anyone physically harmed the resident, if yes provide details; 2) has staff yelled or cursed at you; 3) does the resident feel comfortable asking staff for assistance; and 4) does staff treat you with respect. No potential abuse was noted.</p> <p>Record review of Resident Skin Assessments, dated 4/9/2025, reflected 17 assessments were performed for non-verbal residents with no abnormal findings.</p> <p>The ADO and Administrator were informed that the IJ was removed on 04/10/2025 at 4:46 a.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on observation, interview, and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment the facility had evidence that all alleged violations were thoroughly investigated and prevent further abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 7 residents (Residents #1) reviewed for abuse/neglect.</p> <ol style="list-style-type: none"> 1. The facility failed to investigate an allegation of sexual abuse of Resident #1. 2. The facility failed to prevent further potential abuse and mistreatment by allowing the alleged perpetrator to remain in the facility and to have direct contact with the residents. <p>An Immediate Jeopardy (IJ) situation was identified 04/09/25. While the IJ was removed on 04/10/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at risk for abuse, physical harm, psychosocial harm, trauma, unrecognized abuse and emotional distress.</p> <p>The findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/09/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes), hypertension (high blood pressure), hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (lack oxygen to the brain causing damage to brain tissue) affecting left non-dominant side, and lack of coordination.</p> <p>Record review of Resident 1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment. Section GG - Functional Abilities revealed Resident #1 required substantiated/maximal assistance with toileting hygiene and shower/bathing.</p> <p>Record review of Resident #1's Care Plan, dated 04/09/2025, revealed a focus area which reflected Resident #1 had an ADL self-care performance deficit. Part of the interventions reads in part, Bathing requires staff x1 for assistance.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 10:44 a.m., Resident #1 said back on a day in January 2025, CNA O took him to a shower and while bathing the resident, CNA O stuck his finger inside Resident #1's anus once for about a second. Resident #1 said there were no other witnesses at the time of the incident. Resident #1 said he did not initially report the incident to anyone because he was embarrassed. Resident #1 said he was not injured or in any discomfort after the incident occurred. Resident #1 said he reported it to facility staff a few days later but could not remember who. Resident #1 said the facility did not do anything about what he reported because CNA O was still working at the facility although had not given Resident #1 any more showers. Resident #1 said he did not remember talking to any administrator or anyone else about what he reported. Resident #1 said this made him upset because he would not want another resident to go through what he went through. Resident #1 said CNA O did not work with him anymore after the incident.</p> <p>During an interview on 04/09/2025 at 12:22 p.m., CNA N said about two-three months ago, Resident #1 said he had been sexually abused by CNA O. CNA N said Resident #1 told another staff member during another shift about the allegation and CNA N believed the staff reported it to administration. CNA N said he did not report the allegation to anyone else because he thought it had already been reported. CNA N said he believed it was the Administrator who told staff males could not go into the room, and if they must go into Resident #1's room it needed to be with another staff. CNA N said CNA O was not suspended and stayed working on the floor with other residents. CNA N said no other residents complained about CNA O. CNA N said he did not know if anything was done about the allegation.</p> <p>During an interview on 04/09/2025 at 2:25 p.m., LVN H said Resident #1 refused to have males work with him. LVN H said Resident #1 just said to her he did not like one specific male CNA (CNA O) and was okay with the other male CNAs. LVN H said she did not know why Resident #1 did not want CNA O to work with him.</p> <p>During an interview on 04/09/2025 at 2:33 p.m., CNA P said she heard from other staff that a male was not supposed to take care of Resident #1. CNA P said she did not know why. CNA P said she did not know if the information was documented anywhere.</p> <p>During an interview on 04/09/2025 at 2:49 p.m., LVN F said one day about 3 or 4 months ago, CMA M informed LVN F Resident #1 was complaining about being sexually molested. LVN F said he talked with Resident #1 and the resident told him he felt he was sexually molested by inappropriate touching by a staff member. LVN F said Resident #1 did not say which staff at the time. LVN F said Resident #1 said he did not want any males working with him. LVN F said he reported the allegation to ADON E. LVN F said he believed ADON E reported it to the Administrator. LVN F said ADON E told him to make sure no males went into the room with Resident #1. LVN F said he then informed the staff on the floor about the instructions ADON E told him regarding no males in Resident #1's room. LVN F said the allegation was reported by Resident #1 days after the alleged incident occurred. LVN F said Resident #1 did not complain about any discomfort or injury. LVN F said he did not remember if he documented the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 3:37 p.m., the ADON E said all allegations reported needed to be reported to the Administrator or the DON right away. The ADON E said she had the DON and Administrator's numbers, and they were on-call 24/7. The ADON E said one evening several months back, LVN F said Resident #1 felt he was abused two to three days before when he was getting showered and while staff cleaned his buttocks, Resident #1 felt CNA O touched him inappropriately. The ADON E said he asked LVN F to write him a statement. ADON E said he called the Administrator on the phone and told her there was an allegation of abuse in the building. ADON E could not recall the time he called the Administrator. The ADON E said he instructed LVN F no males were allowed in Resident #1's room. ADON E said Resident #1 was informed and he did not have a problem with any other male CNAs, and only CNA O. ADON E said he told LVN F to document the incident on the 24-hour report. ADON E said the written statement by LVN F was given to the Administrator and he did not know what the Administrator did then.</p> <p>During an interview on 04/09/2025 at 4:19 p.m., CMA M said she was trained to report allegations of abuse, to include sexual abuse, to the charge nurse and Administrator immediately. CMA M said several months ago, Resident #1 reported to her he did not want CNA O in his room. CMA M said Resident #1 said CNA O touched him inappropriately on his backside. CMA M said she told LVN F, but she did not contact the Administrator. CMA M said she knew she should have informed the Administrator but failed to do so since she told LVN F. CMA M said CNA O still worked at the facility but did not provide any patient care to Resident #1.</p> <p>During an interview on 04/09/2025 at 4:30 p.m., CNA O said he had been working at the facility for [AGE] years. CNA O said he had been trained on reporting abuse/neglect allegations immediately to the Administrator. CNA O said no residents complained to him about any abuse or inappropriate touching. CNA O said he had not been suspended for any incidents or allegations. CNA O said no resident had complained about him. CNA O said he was familiar with Resident #1 and the resident did not want any males in the room. CNA O said Resident #1 did not have any problems with him. CNA O said he was told by LVN F not to work with Resident #1 with no other explanation. CNA O denied any knowledge of any sexual abuse.</p> <p>During an interview on 04/09/2025 at 5:05 p.m., the Administrator said her responsibility when it came to allegations of abuse, neglect, or exploitation was to protect the resident, gather information, and proceed with the investigation. The Administrator said she was also responsible to contact the State Survey Agency and if needed law enforcement. The Administrator said all allegations of abuse would be reported to the State Survey Agency within 2 hours. The Administrator said if there were any allegations of sexual abuse, the allegation would be reported to the State Survey Agency, law enforcement, and the physician and responsible parties. The Administrator said she had not received any reports of any type of sexual abuse. The Administrator said she was familiar with Resident #1, and he had not made any complaints with her. The Administrator denied being notified or having any knowledge of any alleged sexual abuse which involved Resident #1.</p> <p>Record review of Resident #1's Progress Notes from January 2025 to April 2025 did not reveal any documentation regarding the allegation of sexual abuse.</p> <p>Record review of Social Service Quarterly Assessment for Resident #1, dated 01/17/2025 at 4:00 p.m., read in part, Resident can have times when he becomes upset at staff but for the most part gets along well with everyone. At this time there are to be no male CNAs in resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the 24-hour reports for the month of January 2025, did not reveal any information on the allegation of sexual abuse.</p> <p>Record review of TULIP revealed no prior self-reports related to the allegation of abuse which involved Resident #1 from 01/01/2025 to 04/09/2025.</p> <p>Record review of a copy of a statement written by CMA M, dated 1/14/2025, read To whom it may concern, On Wednesday, January 8th, [CMA M] reported to [LVN F] nurse in charge of [Resident #1] reporting an incident of sexual harassment. [Resident #1] stated that he was upset with [CNA O]. [Resident #1] said that [CNA O] inserted his fingers while [CNA O] was showering him. [CMA M] immediately reported to [LVN F].</p> <p>Record review of the facility provided Abuse/Neglect policy, with revision date 3/29/2018, read in part All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Investigation .Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 04/08/2025 at 8:00 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 04/08/2025 at 8:00 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 4/10/2025 at 1:40 p.m.:</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Abuse allegation investigations started on 4/9/2025 and are ongoing. Furthermore, as per policy, all new investigations start immediately upon receiving an allegation. - The resident was interviewed at the time of discovery on 4/9/2025 and could not recall exact details of the event due to diagnosis of vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to damage and cognitive decline). He does not recall in the same way today, but the general allegation remains the same. A trauma informed care assessment was completed by the DON on 4/9/2025. Results were no negative outcomes. - One on One in-service on Abuse Reporting with the Administrator, DON, by Area Director of Operation (ADO) on 4/9/2025 at 20:08. - One on One in-service on Investigating allegations with the Administrator, DON, by ADO on 4/10/2025 at 10:23am. - Staff working with alleged perpetrators have been interviewed by the Administrator, Director of Nursing, ADO, and Compliance Nurse. Statements revealed the medication aide was the first to learn of the concern, she reported to the charge nurse who reported to the ADON. The ADON reported he phoned the administrator and left copies of the statements with her. All interviews were completed on 4/9/2025. The resident is doing ok; no distress was noted, and the resident was able to voice concerns. - The alleged perpetrator was suspended on 4/9/2025 at 6:00 p.m., pending the outcome of the investigation. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - The ADON was suspended on 4/9/2025 at 9:00 p.m., pending the outcome of the investigation. - Notification of Authorities: Law enforcement and HHSC were notified promptly in accordance with state-mandated reporting guidelines on 04/09/2025. - Emotional Support: Social services and/or a mental health provider were contacted to provide counseling and emotional support to the resident; referral was sent as on 04/09/2025. - All residents who were able to be interviewed had safety surveys on 4/9/2025 by the social worker. No abuse incidents were reported. All surveys were completed on 4/9/2025. - All residents who were able to be interviewed were interviewed by DON/Compliance Nurse/Social worker on 4/9/2025. A new skin assessment was completed on all non-verbal residents, by the same group was completed on 4/9/2025 with no abnormal findings (unknown bruises, skin tears, abrasions). -The following in-services were initiated on 4/9/2025 by the Administrator/ADO: Any staff member not present or in-service on 4/9/2025 will not be allowed to assume their duties until in-service. These will be completed by 4/10/2025. - All Staff ? Abuse/Neglect with special focus on sexual abuse ? Abuse/Neglect Reporting ? Who to Report Abuse/Neglect to Administrator and Director of Nursing <p>Previously this was to be reported to only the administrator, but a second layer of reporting was added to prevent oversight of a single individual.</p> <ul style="list-style-type: none"> - All in-serviced staff will need to be able to articulate back on reporting any abuse allegation and to whom to report by 4/10/2025 -The administrator/designee will assess and monitor understanding by quizzing and providing examples on in-services beginning 4/9/2025. - New staff will be in service during orientation before assuming any duties. - The medical director was notified of the immediate jeopardy situation on 4/9/2025 at 8:23 p.m. - The administrator will report any abuse allegations, investigate, and submit findings to the Area Director and Risk Management for review. 4 weeks and PRN thereafter. -The administrator will submit documentation of the investigation with Resident and Staff interviews, as well as weekly follow-up interviews with staff and residents x 4 weeks to ensure resident safety/satisfaction with the outcome of the investigation. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Grace Pointe Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 N Oregon St El Paso, TX 79902	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- The Area Director will monitor abuse allegations reported by residents and or staff and check the real-time system, which monitors keywords like abuse x 4 weeks' documentation and PCC for any incidents and accidents.</p> <p>- The QA committee will review the findings of abuse allegations and investigations monthly and make changes to the system as needed. 4 weeks until substantial compliance is achieved.</p> <p>Monitoring of the facility's plan of removal included the following:</p> <p>During an interview on 04/10/2025 at 1:50 p.m., the ADO stated an investigation into the allegation of sexual abuse was started on 04/09/2025 and continuing. The ADO said she in-serviced the DON and Administrator one-on-one regarding the reporting of abuse and investigating allegations. The ADO said all new investigations would start immediately upon receiving an allegation. The ADO said CNA O and ADON E were suspended pending the investigation. The ADO said a referral for emotional support was sent on 4/9/2025 to provide counseling and emotional support to Resident #1. The ADO said part of the plan included all new staff would be in-serviced during orientation. The ADO said the Administrator would submit documentation of the investigation and have weekly follow-up interviews with staff for 4 weeks to ensure resident safety. The ADO said she would monitor abuse allegations reported by residents and/or staff and check the real-time system for keywords like abuse for 4 weeks. The ADO said the QA committee would review findings of all abuse allegations and investigations monthly and make changes as needed.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., the DON stated an investigation into the allegation of sexual abuse started on 4/9/2025. The DON stated being in-serviced by ADO regarding new investigations would start immediately upon receiving an allegation. The DON said CNA O and ADON E were suspended pending investigation. The DON said residents who were able to be interviewed were interviewed and a skin assessment was completed on all non-verbal residents on 4/9/2025.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., the Administrator stated an investigation into the allegation of sexual abuse started on 4/9/2025 and CNA O and ADON E were suspended pending the investigation. The Administrator stated ADO in-serviced her on new investigations needing to start immediately upon receiving an allegation. The Administrator said staff working with the alleged perpetrator were interviewed on 4/9/2025. The Administrator said law enforcement was contacted on 4/9/2025. The Administrator said all facility staff, before assuming their duties, were in-serviced on abuse/neglect with focus on sexual abuse, abuse/neglect reporting, and who to report allegations of abuse/neglect to, being the Administrator and the DON.</p> <p>During an interview on 04/10/2025 at 2:01 p.m., CNA N who works the 6:00 a.m. to 2:00 p.m. shift, said he said he was in-serviced on abuse/neglect. CNA N said all allegations to include sexual abuse, needed to be reported to the DON and the Administrator immediately after ensuring resident were safe. CNA N was able to point out where to locate the contact number posting.</p> <p>During an interview on 04/10/2025 at 2:03 p.m., LVN J who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN J said all allegations of abuse/neglect to include sexual abuse were to be reported to the Abuse Coordinator/Administrator and DON immediately as soon as verifying the resident was safe. LVN J was able to point out where to locate the posted contact numbers for the Administrator and DON.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 2:04 p.m., LVN K who works the 6:00 a.m. to 2:00 p.m., shift, said she was in-serviced on abuse/neglect and reporting. LVN K said when it came to abuse/neglect, she must make sure the resident was safe from any abuse and then immediately report the allegation to the DON and Administrator/Abuse Coordinator. LVN K was able to point out where to find the posted contact numbers for the Administrator and DON.</p> <p>During an interview on 4/10/2025 at 2:05 p.m., LVN G who works 6:00 a.m. to 2:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN G said all allegations of abuse/neglect which included sexual abuse must be reported immediately to the Abuse Coordinator and the DON. LVN G was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>During an interview on 4/10/2025 at 2:06 p.m., CNA S who works 10:00 p.m. to 6:00 a.m. shift, said she was in-serviced on abuse/neglect reporting. CNA S said for all allegations of abuse/neglect which included sexual abuse, it should be reported immediately to Abuse Coordinator and DON after seeing the resident was safe. CNA S was able to point out where to locate the contact numbers for the DON and the Administrator.</p> <p>During an interview on 4/10/2025 at 2:09 p.m., LVN F who works the 2:00 p.m. to 10:00 p.m. shift, said he was in-serviced on abuse/neglect reporting. LVN F said he was responsible to protect residents and make sure they were safe and then report all allegations to the Abuse Coordinator/Administrator and the DON immediately. LVN F was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:10 p.m., CNA T who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. CNA T said she needed to make sure residents were safe and then report it right away to the Administrator and the DON. CNA T was able to point out where to locate the posted contact numbers for the DON and Administrator.</p> <p>During an interview on 4/10/2025 at 2:11 p.m., LVN H who works the 2:00 p.m. to 10:00 p.m. shift, said she was in-serviced on abuse/neglect reporting. LVN H said when it came to allegations of abuse/neglect, first make sure the resident was safe, and then call the Administrator/Abuse Coordinator and the DON immediately as soon as possible. LVN H was able to point out where the posted contact numbers for the DON and Administrator were located.</p> <p>During an interview on 4/10/2025 at 2:18 p.m., CNA R said she was in-serviced on reporting abuse/neglect allegations. CNA R said it was the staff responsibility to make sure the resident was safe and then immediately report to the Administrator/Abuse Coordinator and the DON. CNA R was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:20 p.m., HK Z said she was in-serviced on reporting abuse/neglect. The HK staff said her responsibility was to report any allegations of abuse/neglect to the Abuse Coordinator and the DON immediately. The HK was able to point out where to locate contact numbers for the Administrator and the DON.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 2:23 p.m., LVN L who works multiple shift times from 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m., said he was in-serviced on abuse/neglect reporting. LVN L said his responsibility was to keep the residents safe and remove the alleged perpetrator if with the resident. LVN L said he then called the Administrator/Abuse Coordinator and the DON immediately to report the allegation. LVN L was able to point out where to locate contact numbers.</p> <p>During an interview on 4/10/2025 at 2:24 p.m., MA Y said she was in-serviced on reporting abuse/neglect. MA Y said allegations of abuse/neglect which included sexual abuse needed to be reported immediately to the Abuse Coordinator and the DON after making sure the resident was safe. MA Y was able to point out where to locate contact number.</p> <p>During an interview on 4/10/2025 at 2:26 p.m., LVN I who works the 2:00 p.m. to 10:00 p.m. shift, said she received training on abuse/neglect reporting. LVN I said she was responsible to make sure residents were safe and call the Administrator and the DON to report immediately. LVN I was able to point out where the contact numbers of the Administrator and the DON were posted.</p> <p>During an interview on 4/10/2025 at 2:31 p.m., CNA U said she was in-serviced on reporting abuse/neglect. CNA U said she was trained to make sure residents were safe and report allegations of abuse/neglect, to include sexual abuse, to the Abuse Coordinator and the DON immediately.</p> <p>During an interview on 4/10/2025 at 2:35 p.m., the Activity Director said she was trained on reporting abuse/neglect. The Activity Director said for allegations of abuse/neglect, she would report immediately to the Abuse Coordinator/Administrator and the DON. The Activity Director pointed out where the contact numbers were for the DON and Administrator were located.</p> <p>During an interview on 4/10/2025 at 2:38 p.m., Dietary Staff W said she was trained on reporting abuse/neglect. Dietary Staff W said if she suspected or witnessed any abuse/neglect, she would make sure the resident was safe and then report it to the Abuse Coordinator/Administrator and the DON immediately.</p> <p>Record review of the Facility's In-Service training records titled Self-Reporting Protocol/Ad Hoc QAPI dated 4/9/2025, revealed allegation reported to the State; alleged perpetrator suspended; resident interviewed; interview of resident roommate; interviews with interviewable residents regarding staff treatment; skin assessment for residents who are unable to be interviewed; interview of staff regarding if they observed any potential abuse; performed a Trauma Informed PRN Assessment; notification to law enforcement; notification of medical director; were conducted and signed by the Administrator and the DON.</p> <p>Record review of the facility's document titled In-Service Training Attendance Roster, dated 4/9/2025, reflected that ADO conducted one-on-one in-services with the Administrator and the DON on training topic of allegation reporting guidelines.</p> <p>Record review of the facility's documentation regarding investigating allegations, revealed witness statements were taken on 04/09/2025 related to the allegation of sexual abuse, from Resident #1, the DON, ADON E and the Administrator.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Facility's In-Service Training records revealed training was conducted on 4/10/2025. The in-services were, dated 4/9/2025 and 4/10/2025, and included the topics of abuse/neglect/exploitation, abuse/neglect reporting, and who to report allegations of abuse/neglect to. Seventy-eight (78) out of (81) staff had signed the in-service training forms.</p> <p>Record review of Employee Disciplinary Reports, dated 04/09/2025, revealed CNA O and ADON E were placed on suspension pending investigation.</p> <p>Record review of the Police Department Incident Information Card, dated 4/9/2025, revealed a police report was made.</p> <p>Record review of Order, dated 4/10/2025, revealed an order for Resident #1 for counseling and emotional support services.</p> <p>Record review of Trauma Informed PRN Assessment, dated 04/09/2025, revealed the assessment was completed for Resident #1 by the DON.</p> <p>Record review of Resident Safe Surveys, dated 4/9/2025, reflected 45 resident surveys were conducted. The document covered the areas of 1) had anyone physically harmed the resident, if yes provide details; 2) has staff yelled or cursed at you; 3) does the resident feel comfortable asking staff for assistance; and 4) does staff treat you with respect. No potential abuse was noted.</p> <p>Record review of Resident Skin Assessments, dated 4/9/2025, reflected 17 assessments were performed for non-verbal residents with no abnormal findings.</p> <p>The ADO and Administrator were informed that the IJ was removed on 04/10/2025 at 4:46 a.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 7 residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to develop a comprehensive person-centered care plan regarding information found in a Social Services Quarterly Assessment that no male CNAs should be in Resident #1's room.</p> <p>This deficient practice could place residents at risk of not receiving the necessary care or services.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/09/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes), hypertension (high blood pressure), hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (lack oxygen to the brain causing damage to brain tissue) affecting left non-dominant side, and lack of coordination.</p> <p>Record review of Resident 1's Quarterly MDS dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment.</p> <p>Record review of Social Service Quarterly Assessment for Resident #1, dated 01/17/2025 at 4:00 p.m., read in part, Resident can have times when he becomes upset at staff but for the most part gets along well with everyone. At this time there are to be no male CNAs in resident's room.</p> <p>Record review of Resident #1's Care Plan, dated 04/09/2025, revealed no documentation regarding no male CNAs in resident's room.</p> <p>During an interview on 04/09/2025 at 12:22 p.m., CNA N said about two months ago Resident #1 made an allegation of sexual abuse by CNA O. CNA N said he believed following the reported allegation, the Administrator told staff males could not go into the room and if they must go, they needed to be with another staff member.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 12:37 p.m., the SW stated she had been in her position for about a month. The SW said the previous SW, who was no longer employed at the facility, completed the Social Service Quarterly Assessment, dated 1/17/2025. The SW said she was not aware Resident #1 had any instructions or preferences regarding no male CNAs in his room. The SW said she met with Resident #1, and he did not voice any concerns regarding male CNAs. The SW said she did not know why this information was included in the assessment. The SW said she did not know if the request was followed through.</p> <p>During an interview on 04/09/2025 at 1:41 p.m., the DON said she was not aware of Resident #1 having any concerns regarding male CNAs in his room. The DON said if the information was based on a social worker assessment, then it would have been care planned regarding preferences. The DON said Resident #1 did not have any specific preferences she was aware of. The DON said she did not know why the information was written on the assessment but not care planned. The DON said it would have been the responsibility of the former SW to care plan the information. The DON said she did not know if the request was implemented regarding male CNAs not entering Resident #1's room.</p> <p>During an interview on 04/09/2025 at 2:16 p.m., LVN G said Resident #1 preferred female staff taking care of him and did not want males in his room. LVN G said he did not know the reason why. LVN G said he did not know if the information was care planned.</p> <p>During an interview on 04/09/2025 at 2:25 p.m., LVN H said Resident #1 refused to have males work with him. LVN H said Resident #1 just said to her he did not like one specific male CNA (CNA O) and was okay with the other male CNAs. LVN H said she did not know why Resident #1 did not want CNA O to work with him.</p> <p>During an interview on 04/09/2025 at 2:33 p.m., CNA P said she heard from other staff that a male was not supposed to take care of Resident #1. CNA P said she did not know why. CNA P said she did not know if the information was documented anywhere.</p> <p>During an interview on 04/09/2025 at 2:49 p.m., LVN F said one day about 3 or 4 months ago, CMA M informed LVN F Resident #1 was complaining about being sexually molested. LVN F said he talked with Resident #1 and the resident told him he felt he was sexually molested by inappropriate touching by a staff member. LVN F said Resident #1 did not say which staff at the time. LVN F said Resident #1 said he did not want any males working with him. LVN F said he reported the allegation to ADON E. LVN F said ADON E told him to make sure no males went into the room with Resident #1. LVN F said he did not remember if he documented the incident.</p> <p>During an interview on 04/09/2025 at 3:37 p.m., the ADON E said one evening several months back, LVN F said Resident #1 felt he was abused two to three days before when he was getting showered and while staff was cleaning his buttocks, Resident #1 felt CNA O touched him inappropriately. ADON E said he instructed LVN F no males were allowed in Resident #1's room. ADON E said Resident #1 was informed and said he did not have a problem with any other male CNA, and only CNA O. The ADON E said he told LVN F to document the incident on the 24-hour report. ADON E said nothing was brought up in the morning meeting the following day. ADON E said he did not document any of the events or instructions regarding no male CNAs in Resident #1's room, anywhere .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/2025 at 3:25 p.m., the DON said the purpose of a care plan was to individualize care for a resident's needs. The DON said the information on the SW assessment regarding no males in Resident #1's room should have been care planned. The DON said since it was the SW's observation, the SW should have ensured it was care planned. The DON said if the SW would have communicated the information to nursing or the MDS Coordinators, then they could have taken care of making sure it was care planned. The DON said the risk of not having an accurate or updated care plan was the care plan would not be individualized to ensure the resident preferences were respected and possibly get the care the resident needed.</p> <p>During an interview on 04/10/2025 at 3:35 p.m., the Administrator said the purpose of a care plan was to make everyone aware of individualized care and paints the picture of the resident and their needs. The Administrator said the information found in the SW assessment should have been care planned by the former SW. The Administrator said the risk of not care planning the information was Resident #1's preferences would not be known.</p> <p>Record review of the facility provided, undated, Comprehensive Care Planning policy, revealed in part Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217</p> <p>Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 7 residents (Resident #1) reviewed for accuracy and completeness.</p> <p>The facility failed to document an allegation of sexual abuse was made by Resident #1's.</p> <p>This deficient practice could place residents at risk for abuse, neglect, exploitation.</p> <p>Findings included:</p> <p>Record review of Resident #1's Admission Record, dated 04/09/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: vascular dementia (type of dementia caused by conditions that disrupt blood flow to the brain, leading to cognitive and behavioral changes), hypertension (high blood pressure), hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (lack oxygen to the brain causing damage to brain tissue) affecting left non-dominant side, and lack of coordination.</p> <p>Record review of Resident 1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1's Progress Notes from January 2025 to April 2025 did not reveal any documentation regarding the allegation of sexual abuse.</p> <p>Record review of 24-hour reports for the month of January 2025, did not reveal any information on the allegation of sexual abuse.</p> <p>During an interview on 04/09/2025 at 10:44 a.m., Resident #1 said back on a day in January 2025, he was inappropriately touched by CNA O during a shower. Resident #1 said he did not initially report the incident to anyone because he was embarrassed. Resident #1 said he reported it to facility staff a few days later but could not remember who.</p> <p>During an interview on 04/09/2025 at 2:49 p.m., LVN F said one day about 3 or 4 months ago, CMA M informed LVN F Resident #1 complained about being sexually molested. LVN F said he did not remember if he documented the incident.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Grace Pointe Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/2025 at 3:37 p.m., ADON E said one evening several months back, LVN F said Resident #1 felt he was abused two to three days before when he was getting showered and while staff was cleaning his buttocks, Resident #1 felt CNA O touched him inappropriately. ADON E said he asked LVN F to write him a statement. ADON E said he called the Administrator on the phone and told her there was an allegation of abuse in the building. ADON E said the Administrator told him she was out of the building at lunch, but when she came back, she would follow-up on the allegation. ADON E said he instructed LVN F no males were allowed in Resident #1's room. ADON E said he told LVN F to document the incident on the 24-hour report. ADON E said he did not document any of the events anywhere.</p> <p>During an interview on 04/10/2025 at 3:35 p.m., the Administrator said there was no documentation in the progress notes or the 24-hour reports that mentioned any allegation of sexual abuse. The Administrator said she did not receive any statements, incident report, or any other documentation related to the allegation of sexual abuse. The Administrator said it was very important all events including allegations were documented for continuity of resident care. The Administrator said if there was no documentation, how would prove anything happened. The Administrator said nursing staff and IDT were responsible to ensure resident records were accurate and complete. The Administrator said the risk of inaccurate records could affect continuity of care which may be interrupted, delay, or specific incidents could be overlooked.</p> <p>Record review of the facility provided Documentation policy, revised May 2015, read in part Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets . Goal .the facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. The facility will ensure that information is comprehensive and timely and properly signed.</p>		