

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  08/05/2025
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 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>(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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure that information is comprehensive, timely and properly signed for 1 of 9 residents (Resident #3) reviewed for accuracy and completeness. The facility failed to document when Resident #3 complained of pain to the right lower extremity. This failure could place residents at risk for incomplete or inaccurate clinical records, which could lead to miscommunication, a delay in treatment, or a potential decline in the resident's health. Findings included: Record review of closed admission Record dated 07/31/25 for Resident #3, revealed Original admission Date: 03/07/25; re-admission date 03/21/25. Date of discharge: [DATE] at 12:30 PM to hospital. Review of Hospital Operative Record dated 04/17/25 for Resident #3 revealed, Date of Surgery: 04/17/25. Preoperative diagnosis: Right reverse obliquity intertrochanteric femur fracture (is a break in the upper part of the right thigh bone femur, specifically in the area between the two bony bumps) due to osteoporosis (is a condition where bones become weak and brittle, making them more likely to break). Procedure: Right femur cephalomedullary nail (is a specific surgical procedure to fix a broken thigh bone (femur) particularly fractures near the hip joint). Indication for procedure: this is a [AGE] year-old female with multiple comorbidities (when someone has two or more illnesses or diseases at the same time) including quite severe renal osteodystrophy (is a serious bone disease that develops as a complication of advanced, long-standing kidney disease), sustained a fall from standing 4 weeks ago. She was seen in my clinic 2 days ago where I diagnosed a right reverse obliquity intertrochanteric femur fracture. Review of Hospital X-ray report dated 02/23/25 for Resident #3 revealed, X-ray Right knee, Impression: No acute osseous (joint appears normal, no fracture or infection seen in x-ray) or joint centered abnormality. Review of Hospital X-ray report dated 02/23/25 for Resident #3 revealed, X-ray Right lower Leg, Impression: No acute osseous (joint appears normal, no fracture or infection seen in x-ray) or joint centered abnormality. Record review of Nursing Facility History &amp; Physical dated 03/07/25 for Resident #3, revealed [AGE] year-old recently had a fall and injured her right leg and currently in brace. Patient was admitted due to worsening pain and swelling of right lower extremity. Plan: Admit to SNF, PT and OT to evaluate, Multimodal Pain and Fall precautions. Record review of admission MDS dated [DATE] for Resident #3, functional limitation in range of motion-impairment on one side to lower extremity, mobility device-wheelchair, partial/moderate assistance to roll left and right; sit to lying; lying to sitting on side of bed; dependent - with sit to stand, transfer from bed to chair; substantial/maximum assistance with toilet transfer/shower transfer; received PRN pain medication; pain presence - none; History of Falls in the last month prior to admission; no falls since admission. Record review of Care Plan for Resident #3, revealed uncontrolled pain. Date Initiated: 03/10/2025 Revision on 04/04/2025 revealed:- Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.- Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.- Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.- Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's experience of pain.- Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.- Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx or c/o pain or discomfort.- Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment.- Monitor/record/report to Nurse any sign/symptoms of non-verbal pain: Changes in breathing(noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out,silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy,constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face(sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Record review of Physician Order Summary dated 07/31/25 for Resident #3, revealed Observation: Pain - Observe every shift. If pain present, complete pain flow sheet and treat trying non pharmaceutical interventions prior to medicating if appropriate. Document and the progress note every shift for pain management. Ortho consult status post femur fracture. Portable x-ray of right knee for diagnosis of knee pain. PT to eval and treat as warranted. Orthopedic appointment on 04/15/25 at 9:00 AM. Acetaminophen-Codeine 300-30 mg give 1 tablet by mouth every 6 hours as needed for pain Gabapentin 300 mg at bedtime for right thigh pain Tylenol 325 mg give 650 mg by</p>		