

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  12/31/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to document accurately on Resident #1's EMAR for Acetaminophen with Codeine 300-30 MG tablet, 1 tablet. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included: Record review of Resident #1's face sheet dated 12/29/25 noted she was a [AGE] year-old female with admission date 08/28/25. Record review of Resident #1's health and physical dated 12/23/25 revealed a medical history of Lupus Erythematosus (an autoimmune disease where the immune system mistakenly attacks the body's own tissues, causing inflammation and tissue damage). Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. Record review of Resident #1's care plan, last revised 12/29/25, revealed resident had a potential for uncontrolled pain secondary to Systemic Lupus Erythematosus. Staff intervention included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Nursing staff were to evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability. Record review of Resident #1's physician order dated 10/22/25 noted medication Acetaminophen with Codeine 300-30 MG tablet Give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #1's physician order dated 11/05/25 noted medication Acetaminophen with Codeine 300-30 MG tablet Give 2 tablets by mouth every 6 hours as needed for pain. Record review of Resident #1's Electronic Medication Administration Record (EMAR) revealed resident was administered Acetaminophen-Codeine Oral tablet 300-30 MG Take 2 tablets by mouth as needed for pain as noted by nursing staff on the following dates: 11/08/25 at 08:01 AM, 02:02 PM, 08:00 PM; 11/15/25 at 07:01 AM, and 12:59 PM. Record review of Resident #1's Narcotic Count Sheet revealed nursing staff pulled 1 tablet of Acetaminophen-Codeine Oral tablet 300-30 MG on the following dates: 11/08/25 at 08:00 AM, 02:00 PM, and 08:00 PM; 11/15/25 07:00 AM, and 1:00 PM. Interview on 12/29/25 at 10:50 AM with Resident #1, she stated she was provided 1-2 tablets during the month of November and was only aware of her medication order Acetaminophen-Codeine Oral tablet 300-30 MG take 2 tablets by mouth and was unsure why she would only receive 1 tablet at times. Interview on 12/31/25 at 1:32 PM with MA A revealed only nurses were to administer narcotic medication as needed to residents. She stated nursing staff were trained to perform the 3 checks, confirming the medication label matches the physician order when pulling medications. They stated 3 checks including confirming the name of resident, medication, dosage, time, and how many tablets, before, when, and after pulling medication. She stated nursing staff were trained to document on the EMAR and Narcotic Count Sheet when pulling the medication. MA A stated the nurse pulling the medication was responsible for documenting and administering medication per physician order. She stated the potential risks of not documenting on the correct EMAR order for residents included harming the resident's health by over or underdosing. She stated the ADON and DON were responsible for monitoring Narcotic Count Sheets. MA A stated the facility did provide an in-service regarding the 5 rights for medication but was unable to recall the date. Interview on 12/31/25 at 2:34 PM with LVN B revealed only nurses were to administer narcotic medications. He stated nurses were to document on the EMAR and Narcotic Count Sheet immediately after pulling medication and confirming it was the correct medication. He stated it included name of resident, medication, dosage, and time. He stated nurses monitor Narcotic Count during shift change, 2 nurses count and confirm there were no discrepancies. LVN B stated the DON monitored the Narcotic Count Sheets but was unsure how often. LVN B stated the risk for the resident included double dosing the resident. Interview on 12/31/25 at 3:14 PM with the DON revealed nursing staff were responsible for documenting on the EMAR and Narcotic Count sheet as they pull medications. She stated the purpose of accurately documenting the correct EMAR was to ensure the resident was being treated accurately, according to the physician's orders. She stated the narcotic count would trigger during shift change, which was completed by 2 nurses. She stated as the DON, she monitored monthly, or if notified by nursing staff of discrepancies. Record review of the facility's policy Controlled Medications-Administration dated 2025, read in part: when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the</p>		