STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675106	A. Building B. Wing	06/17/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately discharge for 1 (Resident #3) of 1 resident reviewed for transfer/discharge. The facility failed to ensure Resident #3 was provided a proper 30-day discharge letter from the facility after an incident with LVN R. This failure could place residents at risk of being discharged inappropriately causing a disruption in their care and services and potential decline in health.Record review of Resident #3's face sheet dated 06/16/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and still currently a resident at the facility. Resident #3's diagnoses included Depressive Disorders (feelings of sadness, tearfulness, emptiness or hopelessness), Post Traumatic Stress Disorder (Mental Health Condition that triggered by experiencing or witnessing a terrifying event), and Schizophrenia (brain disorder that makes it hard to tell the difference between what was real and what was imaginary),Record review of Resident #3's Quarterly MDS dated [DATE], reflected a BIMS score of 15, which indicated cognition was intact. Resident #3 had no impairment to of upper extremity (shoulder, elbow, wrist, hand), and no impairment on both sides to lower extremities (hip, knee, ankle, foot). Resident #3 had not exhibit behavior for physical, verbal to others. Resident #3 does reject care, 4 to 6 days but less than daily.Record review of Resident #3's Care Plan dated 06/16/2026, stated focus The Resident has potential to demonstrate verbally abusive behaviors, with a goal; The resident will demonstrate effective coping skills through the review date, interventions/task; Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, notify the charge nurse of any abusive behaviors. Focus Behavior; verbal threats with a goal; episodes of verbal threats will decrease to less than daily in the next 90 days, with interventions/task; be nonjudgmental but firm that inappropriate behavior was not acceptable, intervene if residents shows signs of hostility or anger report to charge nurse ASAP of any incident of behaviorRecord review of Resident #3's Order Summary Report dated 06/16/2026, stated behavioral services to eval and treat as warrantedRecord Review of Resident #3's Progress note dated 05/21/2026 at 06:40 am reveled incident documented by LVN R.Record Review of Resident #3's Progress note dated 06/04/2026 at 13:47 PM reveled a note IDT meeting with meeting with Resident #3. Per admin MD is recommending for resident to discharge to an assisted living facility, where he can have more independent due to nursing home having more rules and regulations. Per administrator 30 day discharge notice will be issued on 6/04/25 social services to find a safe discharge place. Resident requesting to have Ombudsman present care plan schedule for 6/15/26. resident requesting to speak to the doctor as well. Resident #3 refused to sign 30 day notice follow up care plan on 6/15/26 at 1:30pm with IDT team. Last day for 30 day notice will be 7/04/26.Record Review of Resident #3's Provider Note dated 05/19/2026, reveled The patient was seen and examined in hall, patient is freee distress remains AOx3, we are recommending patient to go to another facility due to him being independent and non-compliant. he is leaving the facility daily on the sun metro and is usually gone all day. the staff does report behavioral issues deer oaks has been consulted when he was first admitted but patient refused care. we are consulting dear oaks again patient voices no needs is ambulatory with cane, appetite is good.In an interview on 06/16/2026 at (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:03 am, Resident #3 was alert and oriented and demonstrated the ability to recall dates, names, and prior events with good recollection. Resident #3 stated he had a verbal altercation with LVN R, during which LVN R had called the police. The resident stated he had informed facility staff of the incident and was able to recall the detective's last name. The resident reported he had apologized to LVN R and observed that she appeared frightened and did not shake his hand when he offered it. The resident stated he became emotional and cried because he felt embarrassed by the situation. Resident #3 stated there had been a prior incident with LVN R while entering an elevator. LVN R immediately became upset and instructed him that he should not enter the elevator with her. Resident #3 stated the Social Worker (SW) had not followed up with him regarding how he felt after the altercation with LVN R. The resident stated he had received a letter of discharge that made him feel sad and frightened after the incident, and reported the SW had never explained the reason for his discharge from the facility. Resident #3 stated he understood the SW did not possess a license; therefore, he had contacted the local ombudsman for assistance.In an interview on 06/16/2026 at 01:41 PM, DON stated resident had never been alone with detective during discussions related to the incident. The DON stated the resident had not expressed fear of the detective until the day of the care plan meeting on 06/15/2026. The DON stated she completed a trauma assessment following the care plan meeting to ensure [behavioral services] was informed of the resident's emotional status. The DON stated the detective had last been at the facility in May 2026, and the resident had continued leaving the facility on pass without exhibiting signs of distress or other concerns. The DON further stated the resident had been leaving the facility more frequently than before. DON stated that during the care plan meeting, Resident #3 was explained the discharge notice that was given to him on 06/04/2026, and agreed to tour assisted living facilities contracted through his insurance. The Ombudsman was present during the care plan meeting, and the resident agreed to explore alternative placement options. In an interview on 06/17/2026 at 10:19 AM, Business Manager V stated she had been employed at the facility since 01/08/2026. Business Manager stated the Administrator had informed her that a 30-day notice needed to be issued because the provider had changed the medical necessity care needs for Resident #3. She reported a copy of the letter had also been sent to the Ombudsman. Business Manager V stated that her understanding was the administration had met with Resident #3 on 06/04/2026, and explained the purpose of the letter and its implications regarding his continued residency at the facility. Business Manager V stated she had informed the administrator that the 30-day notice had been issued for nonpayment rather than a transition of care. Business manager V, stated I did my job, if he asked me for the letter, I did it and provided the letter the Administrator to give to Resident #3. She stated she had informed the administrator on 06/04/2026 that the requested letter was not appropriate notice for the residents discharge from the facility.In an interview on 06/17/2026 at 11:30 AM, with Social Worker stated she was the one responsible for generating a 30-day notice of discharge plan for change of treatment plan. She stated she was off the day the wrongful discharge letter was issued to Resident #3 by the Administrator and did not do any assessment or follow up with the letter until his care plan meeting on 06/15/2026. SW stated she coordinated the care plan meeting for Resident #3 and stated she had provided the resident with a letter informing him of the meeting six days prior to the scheduled care plan meeting, but did not follow up with the nonpayment letter that was provided to him on 06/04/2026 she had no reasoning on why she did not follow up. SW stated she was absent for the meeting because she had taken time off to complete licensing testing. The SW stated residents were at risk for emotional distress if their concerns were not properly assessed. She stated her trauma assessment process consisted of asking residents how they were feeling. She stated Resident #3 had verbalized his concerns regarding the altercation between LVN R but he had been referred to behavioral services, mental health services and had obtained assistance through those services. The SW stated she assessed residents if they only expressed concerns during morning meetings or if nursing staff notified her of behavioral concerns the social worker further stated the facility did not have a formal process for conducting (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma assessments and she confirmed that she did not conduct an assessment for Resident #3 in regard to his feelings towards the wrongful discharge letter for nonpayment.In an interview on 06/17/2026 at 12:00 pm, ombudsman, stated he was unaware if facility staff had explained the purpose of the discharge notice to Resident #3 he reported the notice identified as nonpayment as the reason for discharge although the resident had stated he had not experienced payment issues. The ombudsman stated he had not voiced concerns during the meeting because the resident intended to appeal the discharge notice of nonpayment which will be revoked due to that not being the reason of discharge from facility. The ombudsman further stated that the facility had not provided an appropriate discharge notice identifying the resident of his actual discharge status he reported the residence level care had improved however because the resident had permanent Medicaid coverage the facility could not discharge him solely for that reason. The ombudsman stated he had discussed assisted living options with the residents and explained that Medicaid funding would follow the resident he reported the resident did not wish to leave the facility but had only agreed to visit assisted living facilities to consider transfer options. The ombudsman stated he had spoken with the resident multiple times by telephone and text messages he reported the resident initially appeared frightened following the incident involving LVN R and later demonstrated improvement in his emotional status after receiving services through the behavioral services . The ombudsman stated the resident had initially declined counseling and medication but had since accepted therapy and appeared to be doing well.Record review of grievances dated January 2026 through June 2026, revealed the SW had signed grievance documentation since February 2026, none of the grievances were related to the altercation between Resident #3 and LVN R.Record Review of 30 day discharge letter to Resident #3 dated 06/04/2026, revealed notice of discharge, This discharge is based on your failure, after reasonable and appropriate notice, to pay to provide services and your stay at this facility

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review the facility failed to ensure that it employed a qualified social worker on a full-time basis for one of one social worker positions reviewed for social services. The facility, which was licensed for 154 beds, failed to employ a qualified social worker on a full-time basis since 02/09/2026. This failure could place residents at risk of not having their psychosocial or discharge planning needs met. Record Review on 06/16/2026 at 02:27 PM, of an email sent to SW on May 27, 2026, from The Association of Social Work Boards (ASWB) revealed a passing score on the ASWB master's examination. Received preliminary requirements for licensure in the state of Texas and how to obtain forms and instructions on ways to complete the licensing process in the state of Texas,In an interview on 06/16/2026 at 02:35 PM SW stated she had been employed with the facility since February 2026. She stated she had been informed upon hire that she was required to obtain her license within six months of employment. The SW was unable to provide documentation or an employment agreement verifying the six-month licensing requirement. The SW stated she had worked independently after completing a 30 day orientation and reported no individual had routinely supervised or reviewed her work. She stated the facility did not have a regional department on site and that she contacted corporate via email if she had questions. The SW stated no one routinely oversaw her at the facility. In an interview on 06/16/2026 at 02:40 PM with HR Manager stated she had been employed with the facility for about a year in July. HR Manager stated the SW had received an offer letter indicating Licensure was required within six months of hire; however, the facility did not yet have documentation verifying the letter or completion of license. HR manager confirmed the SW did not possess a current license and stated she was not permitted to practice independently. HR Manager stated no one had routinely overseen the SW work and reported that corporate personnel did not physically visit the facility. In an interview on 06/16/2026 at 02:45 PM, Administrator stated that the risk of SW not having a license were residents safety risk, behaviors, and emotional concerns not being assessed. He stated that he was aware of SW not having a license, but the SW had already registered to take the licensing examination after being hired. In an interview on 06/17/2026 at 11:14 am with HR manager stated the facility did not have a written policy regarding the hiring process for anyone at the facility including the SW.Record review of job offer letter for SW dated 02/09/2026 with official start date of 02/23/2026.Record review of Criminal History verification revealed SW hire date of 02/05/2026, with date of first day of service on 02/23/2026.Record review of an employee roster provided by the DON on 06/16/2026 reveled the SW was identified as Unlicensed.Record review of facilities HR-Personnel handbook 2019, revised 09/20/2019, revealed Registered, Licensed, and certified employees; all professionally registered, licensed and certified staff was required to maintain current licensure, registration and/or certification. A Copy of the current documentation must be submitted to your department head for inclusion in your personnel file. Failure to provide the documentation or failure to maintain status may result in suspension and/or termination.Record review of the Texas Administrative Code 554.703 (a)(2) indicated (2) A facility of 120 beds or less must employ or contract with a qualified social worker (or in lieu thereof, a social worker who was licensed by the Texas State Board of Social Worker Examiners, and who meets the requirements of subsection (b)(2) of this section) to provide social services a sufficient amount of time to meet the needs of the residents.