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	03/12/2026

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 8 residents (Residents #2 and Resident #15) reviewed for dignity. -The facility failed on 03/10/2026 to assist Resident #2 to shave her facial hair.-The facility failed on 03/10/2026 and 03/11/2026 to cover Resident #15's genitals and anus. The deficient practice could affect residents by contributing to poor self-esteem, dignity issues and diminished quality of life.The findings included:Record review of Resident #2's face sheet revealed Resident #2 was a 69ˆyearˆold female who was admitted to the facility on [DATE]. Record review of Resident #2's history and physical revealed diagnoses including morbid obesity (severely elevated body weight that increases health risks), schizoaffective disorder (mental illness involving mood symptoms and psychosis), unspecified psychosis (loss of contact with reality), bipolar disorder with manic episode and psychotic features (severe mood disorder with elevated mood and psychosis), major depressive disorder (persistent depressed mood), Parkinson's disease (neurological condition affecting movement), generalized muscle weakness (reduced muscle strength), anxiety disorder (excessive worry), delusional disorder (fixed false beliefs) and personality disorder (persistent pattern of behavior affecting functioning). Record review of Resident #2's MDS admission assessment dated [DATE] revealed the resident had a BIMS score of 14, indicating the resident was cognitively intact and able to communicate needs and preferences. The MDS revealed the resident was able to make decisions regarding daily activities. Review of section GG for functional abilities revealed Resident #2 required substantial to maximal assistance (meaning that staff made more than half the effort by helping to lift and hold trunk or limbs of the resident) with showering and was dependent (meaning the staff made all the effort and the resident does none of the effort to complete the activity) for toileting hygiene, lower body dressing and putting on and taking off footwear. Record review of Resident #2's care plan revealed care plan interventions addressing ADLs and selfˆcare deficits. The care plan revealed the resident required staff assistance with bathing, shaving and personal hygiene tasks. Interventions included staff assistance with grooming and hygiene needs and monitoring the resident's ability to perform personal care tasks. Record review of Resident #15's face sheet revealed the resident had an initial admission on [DATE] and readmission on [DATE]. Record review of Resident #15's history and physical dated 12/16/2025 revealed diagnoses of left (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and right leg amputation at knee level, dementia (a condition that effects an individual's cognition, memory, mood, and behavior) without behavioral disturbance, insomnia (a sleep disorder that effects and individuals ability to fall asleep and stay asleep). Record review of Resident #15's comprehensive MDS dated [DATE] revealed the resident had a BIMS of 07 (meaning the resident had severe cognitive impairment). Review of section I for active diagnosis revealed the resident had an active diagnosis of need for assistance with personal care, attention and concentration deficits, and cognitive communication deficits. Record review of Resident #15's significant change MDS dated [DATE] Review of section C for cognitive patterns revealed the resident had behavior present with fluctuations for inattention, disorganized thinking, and altered level of consciousness. Review of section GG for functional abilities revealed the resident required partial/moderate assistance from staff for lower body dressing. Record review of Resident #15's care plan dated 01/08/2026 revealed care plan interventions addressing resistive to care related to Dementia. The care plan revealed the resident had episodes of inappropriate behavior: wants to keep urinal on the bed side table or siderail without plastic bag, with interventions of ensure staff is aware of resident's behaviors and successful interventions and monitor behaviors to identify any patterns to assist with decreasing number of episodes. During observation and Interview on 03/10/2026 at 9:05 AM with Resident #15, it was observed he was not wearing bottoms as evident by his genitalia being out for the duration of his interview. He stated he did have bottoms on and proceeded to sit restlessly by opening and closing his legs. Follow up observations completed on 03/10/2026 at 12:41 PM, 1:28 PM, and 2:00 PM revealed no change and his partition curtain that divided the room was open for neighbor to view. In a follow-up observation on 03/11/2026 at 2:10 PM, the resident's anus and genitals were visible from the entrance of his fully open doorway and privacy curtain was not in use; Resident #15 was asleep at this time. During an interview on 03/11/2026 at 2:15 PM with LVN G, he stated Resident #15 was resistant to care due to dementia diagnosis as it was his right to refuse care and staff would continue prompting in case he changed his mind. He stated if Resident #15 declined care it would be documented within the facility's resident care portal. He stated the Hospice maintained records of services provided to Resident #15 and he was only responsible for signing off on the Hospice's tablet. He stated Resident #15 had refused to participate in activities, to smoke, baths, grooming, and to wear bottoms or covers. He stated if Resident #15 was within his room, staff would not intervene on his decision to remain bottomless. He stated the curtains needed to be drawn close when Resident #15 wanted to be bottomless. He stated the facility monitored the effectiveness of interventions by asking the resident on preferences and trying to keep his curtain closed. He stated it was difficult to keep the curtains closed because Resident #15 could draw them open himself and required frequent prompting and redirecting. He stated the last in service for dignity was a week prior. During an interview on 3/12/2026 at 10:54 a.m. with CNA F, she stated Resident #15 used to utilize a blanket cover for his lower body as he preferred to not use briefs, underwear, or bottoms. She stated when Resident #15 returned from the hospital in January 2026 he stopped actively covering his lower body. She stated she assisted to cover Resident #15 with a blue blanket on 03/11/2026 at 2:15 PM and closed his door to a small opening. She stated Resident #15 was usually modest and covered himself and clarified a reasonable person would not want to have their genitals exposed and visible from the entrance of their room. She stated Resident #41 who had wandering behaviors would (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident who did not wish to have hair, could result in the resident feeling she was not well taken care of and make her feel like the staff did not care about her wellbeing. During an interview on 03/11/2026 at 9:32 a.m. CNA C stated all staff who assisted residents with ADLs were responsible for checking the resident's facial hair and assisting with shaving if the resident wished to be shaved. CNA C stated the potential negative outcome for a female resident not being assisted with shaving could result in the resident feeling embarrassed and ignored by staff. During an interview on 03/11/2026 at 9:41 a.m. the SW stated that all staff needed to be vigilant and pay attention to the residents' grooming and hygiene. SW stated that if a resident wished to be shaved, especially a female resident, staff needed to ask if they needed assistance. SW stated that by not aiding with grooming and shaving a female resident, it could result in the resident feeling ashamed or embarrassed and feeling ignored by the facility staff, which could negatively impact their self^esteem. During an interview on 03/12/2026 at 9:40 a.m. with the DON, she stated she did not see harm with Resident #2 having long facial hair. She stated Resident #2 had been refusing ADLs, showers, and medications. Record review of the facility's progress notes did not show refusals of ADLs for shaving Resident#2's facial hair. During an interview on 03/12/2026 at 11:28 a.m. with CNA D stated the possible negative outcome of leaving a female resident unshaven when she did not wish to have long facial hair could make the resident feel ashamed which could potentially make the resident self-isolate, and as if the facility staff were not paying attention to her. During an interview on 03/12/2026 at 1:11 p.m. with the Administrator, stated it was the responsibility of every team member to assist the residents with ADLs and hygiene. The Administrator stated that any staff member who had contact with Resident #2 should have asked if she wanted to be assisted with shaving her facial hair and stated failure to help her with shaving could negatively impact Resident #2's self^esteem and confidence. Record review of the facility's policy title Resident Rights dated 11/28/2016 read in part, The resident has a right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy (planning and implementing care section) the right to participate in the development and implementation of his or her person centered place of care, including but not limited to (Respect and Dignity section) the resident has a right to be treated with respect and dignity, including: .the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endager the health or safety of the resident or other residents Record review of the facility's policies and procedures titled Shaving, Electric/Safety Razors, not dated, stated in part: Shaving of the male resident can be performed with an electric or safety razor depending on the preference and availability of equipment. It is usually done as a part of daily personal hygiene, although every other day is sufficient for some based on the beard growth. It is done to promote (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleanliness and a positive body image. Usually, the resident or a staff member performs the procedure, but the nurse can shave the resident if illness or disability prevents independence. Goals 1. The resident will experience cleanliness and comfort. 2. The resident will be free from infection. 3. The resident will maintain intact skin integrity. 1. Assemble the necessary equipment: a basin of warm water (115 degrees F.), shaving cream, the safety razor, a towel, a wash cloth, and aftershave. 2. Wash your hands and put on gloves. 3. Explain what you are going to do. 4. Place a towel under the resident's chin. 5. If the resident wears dentures, be sure they are in his mouth. 6. Put the washcloth in warm water, wring it out, and place it on the face to soften the beard. 7. Apply shaving cream to the face. 8. With the fingers of one hand, hold his skin taut. With the other hand shave in the direction the hair grows. Using short, firm strokes, shave under the sideburns, downward over the cheeks, over the chin, and upward on the neck. 9. Rinse the razor often. 10. Wash the remaining shaving cream off his face. 11. Apply aftershave, if the resident desires it. 12. Store all articles in the appropriate place. 13. When finished, dispose of the gloves and wash your hands.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on observation, interview, and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional for 1 of 1 (activities staff) reviewed for staff qualifications.The facility failed to ensure the activities staff had completed State approved training to direct facility activities.This failure could place residents who participated in facility activities at risk of physiological, psychological, social, and spiritual harm by receiving services from unlicensed personnel.Findings include:During an interview on 3/11/2026 at 8:47 AM the Receptionist stated that the Activities Assistant was the only individual in the Activities department.During an observation on 3/11/2026 at 10:14 AM, the Activities Assistant lead an activity independently with 14 residents present and engaged in physical stretching, meditation, and prayer.During an interview on 3/12/2026 at 10:03 AM the HR Coordinator stated the activities department consisted of one Activities Assistant and a part-time assistant and there was a vacancy for the Activities Director position since 2/20/2026. She stated the Activities Assistant would be transitioning into the Activities Director position once she passed her certification course. She stated the Activities Assistant was leading activities while the Administrator oversaw the operation and helped with the monthly calendar and acquiring supplies. She stated she was unaware if there was a policy that required the Activities Assistant to possess a certificate. She stated it was state/federal requirement for the facility to have an activities director and added the Activities Assistant had a lot of experience. She stated she would not accept an application for a position from someone who was unlicensed when the position required it. She added this was per facility policy and state/federal requirement that employees possess a license/certificate when the position required it. She stated it did not affect residents if the Activities Assistant was not certified. She identified herself as the individual who was responsible for reviewing licenses and certifications for employees. She stated she reviewed employee licenses and certificates on a daily basis. She stated the Activities Director was responsible for organizing resident outings, activities, birthdays, holiday celebrations, events, documenting residents who participated, and transporting residents from their rooms to the gathering. She clarified that all the tasks mentioned were completed by the Activity Assistant since 2/20/2026.During an interview on 3/12/2026 at 11:40 AM the Activities Assistant stated she did not have her certification to be an Activity Director. She stated her responsibilities were to conduct activities, conduct morning rounds, transport residents to activities, provide activities in residents rooms, distribute coffee and utensils before meals, ensured that residents did not fall during activities, prompt residents to participate, and transport residents back to their room. She stated her previous Activities Director had resigned 2 weeks ago and there was a part-time assistant who would help her 2-3 times a week. She added the HR Coordinator and Administrator would follow up with her to help when needed. She stated the Administrator completed the activity calendar for March but that she would be completing the activity calendar going forward. She stated it was a requirement for her to possess a certificate to be conducting the tasks she was actively completing. She stated it effected residents because she could not have ample information or knowledge to complete her responsibilities as an Activities Director.During an interview on 3/12/2026 at 12:30 PM the Administrator stated the Activities Assistant was the department head and had a conditional offer for the Activities Director position. She stated the Activities Assistant did not currently possess a certificate needed to the Activities Director position. She stated the Activities Assistant was given 1 month to complete her training for the certification Activities Director position. She stated she was not aware if it was a state/federal requirement for the Activities Director to possess a certificate or license. She stated that HR oversaw the credentialing and qualifications of staff. She stated that license and certifications provided credentials to prove that someone had the qualifications to complete their job. She added that someone could possess the knowledge even without the pass acknowledgement on an exam. She (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the Activities Director being uncertified did not affect residents because there were course resources available through the facility and additional staff assistance. During an interview on 3/12/2026 at 1:59 PM the DON stated the purpose of a license and certification as used to prove that someone was eligible to provide care or service within their scope of practice. She stated the facility had a regional Activities Director who oversaw the Activities Department at the facility and simultaneously oversaw the Activities department at a sister facility. She stated the Regional Activity Director had not been in the facility for the 3 days of the annual survey. She stated the Activities Assistant had been facilitating the activities because they had been planned, purchased supplies, and provided her with instruction. She stated there was no effect on residents because they were still receiving services and activities. She identified the HR Coordinator and Administrator were responsible for reviewing licensures and credentialing of staff in positions that required a license/certification.Record review of the facility's Job Description for the Activity Assistant dated 2014 read in part, This position reports directly to the Activity Director Record review of the facility's Job Description for the Activity Director dated 2014 read in part, These are legitimate measures of the qualifications for a Activity Director, and are related to the functions that are essential to the job of a Activity Director. Knowledge Base Must be certified Activity Director .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. -The facility failed to ensure dietary staff followed proper food safety practices for cooling and storing prepared food on 03/10/2026. This failure had the potential to place all residents who received meals from the main kitchen at risk for foodborne illness due to, improper food storage practices.Findings included: During an observation on 3/10/2026 at 8:37 a.m. in the facility's kitchen, inside refrigerator #1 revealed: a steam table pan containing oatmeal was observed stored on the bottom rack of the refrigerator, covered with plastic food wrap. Upon assessment, the pan containing oatmeal was noted to be hot to the touch at the time of storage. During an interview on 03/10/2026 at 10:40 a.m., the [NAME] stated hot oatmeal should not have been placed directly into the refrigerator and explained that food must be allowed to cool prior to storage. The [NAME] acknowledged that placing hot food into the refrigerator could promote bacterial growth if proper cooling procedures were not followed, which could result in contaminated food and pose a risk of illness to residents. During an interview on 03/10/2026 at 10:32 a.m., the DS stated oatmeal should have been cooled appropriately by placing it over ice, before being stored in the refrigerator. The DS explained placing hot oatmeal into the refrigerator could raise the internal temperature of the unit, potentially affecting other stored food items. The DS stated this practice could have led to food spoilage, bacterial growth, and increase the risk of residents becoming ill if contaminated food were consumed. During an interview on 03/12/2026 at 9:36 a.m., the DON stated storing hot oatmeal in the refrigerator could have contributed to bacterial growth if proper cooling processes were not followed. The DON stated failure to cool food appropriately prior to refrigeration could have resulted in unsafe food conditions and place residents at risk of illness. During an interview on 03/12/2026 at 1:11 p.m., the Administrator stated food should have been cooled to safe temperatures prior to being placed in the refrigerator. The Administrator stated placing hot food into the refrigerator could increase the internal temperature of the unit, potentially damage the equipment, and compromise its function. The Administrator stated this could have led to spoilage of other food items stored in the refrigerator and increase the risk of bacterial growth. The Administrator stated consumption of improperly stored or contaminated food could place residents at risk of foodborne illness. Record review of the Dietary Services Policy and Procedure Manual, titled Left-Over Foods, dated 2012, stated in part: Left- Over FoodsLeft-over foods shall be handled in a manner to ensure the safe use of these foods at a later date. Procedure:Left-over foods shall be refrigerated, dated, labeled and properly covered promptly after meal service. When cooling large quantities of food, divide into shallow pans and place on ice in the refrigerator. It must reach 70 degrees within 2 hours, and 41 degrees or below within 4 additional hours. Foods are not to be stored at room temperature. Food is to be kept at 41 degrees F or below to prevent bacterial growth.Was he asked who placed it in the fridge? Was this to serve residents? If so, when?These were leftovers from breakfast and he placed it in the refrigerator

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 3 dryers reviewed.The facility failed to ensure the furthest right dryer was operational.This failure placed residents at risk for delay in having their clothes and bedding returned without delay.During an observation on 3/11/2026 at 3:09 PM of the laundry room revealed Laundry Aide I was utilizing 2 of 3 dryers in the laundromat. The furthest right Dryer was rusted, had dust, and was missing its operational panel that covered the top portion of the dryer. The dryer was non-responsive despite moving the knobs and checking for power to the machine. Laundry Aide I confirmed the 3rd dryer was non-operationalDuring an interview on 3/11/2026 at 3:10 PM with Laundry Aide I, she stated she had worked at the facility for 2 years and the 3rd dryer has not been operational for approximately a year. She stated she was not the individual who reported it the dryer was non-operational but suspected it was the day shift laundry aides who reported it to the previous laundry supervisor. She stated that the previous supervisors were informed the dryer did not work because they entered the laundry room approximately 4 times a day. She stated not having the 3rd dryer unit did not affect her ability to complete tasks in a timely manner. She stated if the laundry equipment stopped working, she would report it to her supervisor immediately. She stated this needed to be done so that the process for repairs could be initiated. She stated not having operational dryer affected residents by potentially creating a delay in cleaning sheets, towels, Hoyer nets, personal clothing, etc. She stated residents could be left without clean supplies or clothing. She identified the maintenance director and laundry supervisor were responsible for reviewing the equipment and ensuring it was operational. She stated she had not received training or in-service on reporting broken equipment.During an interview on 3/11/2026 at 3:24 PM with the Laundry Supervisor, he stated t he had been in his position for 2 months. He stated he oversaw the operations for laundry and housekeeping throughout the facility. He stated he had a total of 7 employees to handle housekeeping tasks and laundry. He stated he had not found any documentation from his predecessors about the dryer's dysfunction. He stated the Maintenance Director had notified him that the dryer had not been operational for a year and added that the tumbling drum inside was rusty. He stated he had been aware the dryer was not operational since he began in January. He stated that him nor the facility had no intention on fixing or replacing the dryer because the current census did not require more than 2 dryers. He stated if there was an increase in the census he would partner with sister facilities to meet the new laundry demands. He stated he had no concern for having inoperable equipment in the laundry room. He stated it did not pose a risk for infestations of pests, mice, or infection. He stated if the dryer was removed, it would create more hazard. He stated the maintenance team cleaned the dryer area and behind it weekly. He stated staff was trained to notify him whenever equipment was faulty and to stop use until it was repaired. He clarified this training was provided by word of mouth, and he did not capture in signatures or have a formal in-service log for documentation. He stated the inoperable dryer did not affect residents and added that there had not been a delay in laundry being returned to residents.During an interview on 3/12/2026 at 8:30 AM with the Maintenance Supervisor, he stated he had been in his position for 2 months and had one employee in his department. He stated the facility had 1 dryer in the laundry room and identified it was the 3rd unit (from left to right). He stated he had reviewed the records from his predecessor and discovered the dryer was not fixable and would require a replacement. He stated the facility will be removing the dryer soon and anticipated it being removed in the next 1-2 months. He stated that he had to contact a company to remove it because it could not just be left in the parking lot near the dumpster. He stated the dryer was not obstructing operations and did not affect the facility. He stated residents were not affected because there was still 2 operational dryers and no report of delays. He stated that if a staff member had a work order for him, he was made aware by word of mouth. He identified himself as the individual responsible for (continued on next page)

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	675106	A. Building B. Wing	03/12/2026

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contacting vendors to complete repairs beyond his knowledge.During an interview on 3/12/2026 at 12:41 PM the Administrator stated she was aware the dryer was broken down. She stated there had not been interruption of services for returning laundry to the residents. She stated that the census did not require an extra dryer. She stated that it was going to be removed upon the surveyors' exit. She identified herself and all staff members down the chain of command to report the defective equipment to the Maintenance Supervisor. She stated she had known for 3 months about the dryer's inoperable condition. She stated she was not aware if it was a state or federal requirement for all electrical and mechanical equipment to be fully operational. She stated she had not provided in-training and services and stated it was within the job description of staff to report faulty equipment. She stated the dryer not being operational had not affected the residents and if it did affect them then the facility would prioritize a resolution.A policy pertaining to reporting faulty equipment or maintaining equipment was requested at end of day on 3/11/2026; the facility did not provide such policy.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 1 of 5 residents (Resident #10) reviewed for call lights. The facility failed to ensure Resident #10's call light was within reach on 03/10/2026.This failure placed residents at risk of having their needs unmet when they were unable to contact staff.Findings included:Record review of Resident # 10's admission Record revealed an [AGE] year-old male with an initial admission date of 04/07/2023 and a readmission date of 12/12/2024. Record review of Resident #10's History and Physical dated 10/07/2025 revealed a diagnosis of Dementia (decline in brain function including memory, thinking, and reasoning). Record review of Resident #10's Quarterly MDS assessment revealed a BIMS score of 02 indicating severe cognitive impairment. Section GG revealed resident needed supervision or touching assistance for toileting meaning that the helper provides verbal cues and/or touching/steadying and/ or contact guard assistance as resident completes activity. Record review of Resident # 10's care plan revised on 02/16/2026 revealed Resident #10 had an ADL self-care performance deficit related to clinical illness myopathy (weakness in skeletal muscles), weakness and sarcopenia (age related muscle loss). Interventions included x 1 staff for bed mobility and toilet use. An observation on 03/10/2026 at 10:04am revealed Resident #10 asleep in his bed, and the call light was looped around another call light that was hanging from the wall. During an interview on 03/12/2026 at 9:55 a.m., the DON stated the purpose of a call light was for the resident to be able to make needs known. She stated that the call light should have been within the residents' reach for residents to call for help. She stated that all staff members were responsible for making sure that the call lights were within reach. She stated that this was done by the department heads, during morning rounds, and should have been done during the nurses and CNAs 2-hour rounds. She stated that the risk of the call light not being within reach would have been residents receiving delayed care. She stated the last training was done was last year. During an interview on 03/12/2026 at 10:24 AM RN E stated the purpose of a call light was for the resident to ask for help. She stated that call lights should have been in reach of the resident so they can ask for help. She stated all employees were responsible for ensuring that the call lights were within reach. She stated nurses and CNAs should have also ensured they were properly placed, when doing their rounds. She stated the risk of residents not being able to reach their call light was delay in their care and needs not being met. She stated she could not recall the last Inservice, but they were done frequently. During an interview on 03/12/2026 at 11:24 AM, CNA D stated the purpose of the call light was for the resident to call for help. She stated call lights should have been within reach of the resident. She stated all staff were responsible for ensuring call lights were within reach. She stated as a CNA she ensures call lights were within reach every time she rounded. She stated a risk to the resident was receiving delayed care. She stated she could not recall the last Inservice done over call lights. On 03/12/2026 at 2:30 pm, The DON stated the facility did not have a policy regarding call lights.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of eight residents (Resident #2) reviewed for ADL care. The facility failed on 03/10/2026 to ensure Resident #2's fingernails were clean and trimmed. This failure could place residents who required assistance with ADLs at risk for unmet care needs.Findings included: Record review of Resident #2's face sheet revealed Resident #2 was a 69ˆyearˆold female who was admitted to the facility on [DATE]. Record review of Resident #2's history and physical revealed diagnoses including morbid obesity (severely elevated body weight that increases health risks), schizoaffective disorder (mental illness involving mood symptoms and psychosis), unspecified psychosis (loss of contact with reality), bipolar disorder with manic episode and psychotic features (severe mood disorder with elevated mood and psychosis), major depressive disorder (persistent depressed mood), Parkinson's disease (neurological condition affecting movement), generalized muscle weakness (reduced muscle strength), anxiety disorder (excessive worry), delusional disorder (fixed false beliefs) and personality disorder (persistent pattern of behavior affecting functioning). Record review of Resident #2's MDS admission assessment dated [DATE] revealed the resident had a BIMS score of 14, indicating the resident was cognitively intact and able to communicate needs and preferences. The MDS revealed the resident was able to make decisions regarding daily activities. Review of section GG for functional abilities revealed Resident #2 required substantial to maximal assistance (meaning that staff made more than half the effort by helping to lift and hold trunk or limbs of the resident) with showering and was dependent (meaning the staff made all the effort and the resident does none of the effort to complete the activity) for toileting hygiene, lower body dressing and putting on and taking off footwear. Record review of Resident #2's care plan revealed interventions related to activities of daily living and personal hygiene care. The care plan indicated the resident required assistance with bathing, and personal hygiene. Interventions included staff monitoring and assisting with grooming tasks and maintaining the resident's hygiene needs, including routine care related to nail length and hygiene as part of regular personal care. During an observation and Interview on 03/10/2026 at 10:12 a.m. with Resident #2, she stated she had been at the facility for a month. It was observed that Resident #2 had long fingernails measuring about one inch in length; Resident #2's nails looked yellowish in color and dark particles, and debris were observed underneath her fingernails. Resident #2 stated she would like her fingernails trimmed, but that staff had not offered her assistance. Resident #2 stated she did not like to have long fingernails because she scratched herself and had cut herself in the past. During an interview on 03/11/2026 at 9:20 a.m. with LVN A stated all staff who worked with residents were responsible for checking on the resident's fingernails. LVN A stated during showers or while helping with hygiene, CNAs, LVNs and RNs needed to ask the residents if they wished to have their fingernails trimmed. LVN A stated the potential negative outcome for not trimming a resident's fingernails could result in the resident cutting or scratching themselves and soil their fingernails which could lead to infection and sickness. During an interview on 03/11/2026 at 9:26 a.m. LVN B stated CNAs were responsible for checking the resident's fingernails and trimming them while assisting with showers. LVN B stated if a resident refused to have their fingernails trimmed, whoever was providing shower assistance needed to document it in the resident's progress notes. LVN B stated the potential negative outcome for not trimming the resident's fingernails could have resulted in them scratching themselves, which could lead to infection and potentially make the residents sick if they were to eat, and their fingernails were dirty. During an interview on 03/11/2026 at 9:34 a.m. CNA C stated CNAs and whichever staff assisted a resident with showers were responsible for checking the residents' fingernails and trim them if necessary. CNA C stated that not trimming a resident's fingernails could result in them (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scratching and cutting themselves which could result in infection. She stated that if a resident had long and dirty fingernails and they ate food, it could lead to the resident getting sick or an infection. During an interview on 03/11/2026 at 9:43 a.m. the SW stated all staff from the facility who provided assistance with hygiene to the residents were responsible for asking if they needed their nails trimmed. The SW stated the negative outcome for not trimming a resident's fingernails could result in them scratching themselves, which would lead to bleeding and infections. The SW stated if the resident's nails were not clean and they ate their meals, they could potentially get sick from their stomachs. During an interview on 03/12/2026 at 9:44 a.m. the DON stated she did not see harm with Resident #2 having long fingernails. She stated Resident #2 had been refusing ADLs, showers, and medications. Record review of the facility's progress notes did not show refusals of ADLs for nail trimming. During an interview on 03/12/2026 at 11:30 a.m. CNA D stated any staff who provided assistance with ADLs for Resident #2 were responsible for asking the resident if she needed assistance with trimming her fingernails. CNA D stated the potential negative outcome of leaving Resident #2's fingernails long could have resulted in the resident harming herself if she was to scratch her skin, which could result in skin infections. CNA D stated if Resident #2's fingernails were dirty and she was to eat her meals; she could potentially get sick due to bacteria growth transmitted to her. During an interview on 03/12/2026 at 1:15 p.m. the Administrator stated it was not acceptable that Resident #2 was not assisted with trimming her nails and the potential outcome could be that she scratched herself and she could bleed and it could lead to infection. The Administrator stated if Resident #2 did not wash her hands and had dirty fingernails, she could potentially get sick from her stomach and could lead to vomiting or diarrhea.Record review of the facility's policies and procedures titled Nail Care, not dated, stated in part: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle care and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails all occur in the elderly with some frequency. Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions The resident will be free from infection.ProcedureShould be performed according to the resident centered plan of care. 1. Explain the procedure to the resident.2. Wash hands.3. Immerse hands or feet in a basin of warm soapy water to cleanse and soften the nails for ease in cleansing and trimming. Use a soft brush if necessary to cleanse under and around the nails.4. Remove debris from under the nails with an orange stick while soaking.5. Remove the hands or feet from the basin and pat dry.6. Apply lotion and massage into the cuticles and push back with a towel. Avoid cutting any cuticle.7. Trim the nails with a clipper, straight across for the toenails and rounded for the fingernails.8. Smooth the nails with an emery board.9. Apply hose and shoes or slippers as appropriate.10. Discard removed nails, cleanse basin and articles used and store for future use.14. When performed at bath time, the nail care can be done following the procedure or as a separate procedure when needed at the convenience of the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 (Resident #18) of 5 residents observed for oxygen management.The facility failed to ensure Resident #18's nasal canula was properly stored while oxygen was not in use. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health.The findings include:Record review of Resident #18's admission Record dated 03/10/2026 revealed a [AGE] year-old male with an admission date of 06/06/2025. Record review of Resident #18's History and Physical dated 09/09/2025 revealed a diagnosis of chronic obstructive pulmonary disorder(Long term lung condition caused by damage to the airways and lungs leading to reduced air flow and difficulty breathing). Record review of Resident #18's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 09 indicating moderate cognitive impairment. Special treatment section revealed the use of oxygen therapy. Record review of Resident #18's orders dated 12/03/2025 revealed an order for oxygen at 3 liters per minute via nasal cannula related to chronic obstructive pulmonary disorder. Record review of Resident #18's care plan revised 01/27/2026, revealed Acute respiratory failure with hypoxia chronic obstructive pulmonary disease with acute exacerbation interventions included to give oxygen therapy as ordered by the physician. In an observation in Resident # 18's room on 03/10/2026 at 11:05 am the residents' nasal canula was left exposed on the bed. The resident was not in the room. During an interview on 03/12/2026 at 9:55 a.m., with the DON she stated the oxygen tubing was to be stored in a plastic bag when not in use. She stated she did not see an issue with the nasal canula left exposed on the bed. She stated since it was on the residents' bed, it was not contaminated because it was on his belongings. She stated if nasal cannulas were on the floor then she would expect staff to discard it and replace it. She stated that all staff were responsible to ensure it was stored properly when not in use. She stated the risk of not changing tubing was the risk of infection. She stated the last Inservice was about 1 month ago. During an interview on 03/12/2026 at 10:24 a.m., RN E stated that oxygen tubing and nasal cannulas were to be kept in a plastic bag with a date and the tubing had to be dated as well. She stated the purpose of keeping it in a plastic bag was to keep it from becoming contaminated. She stated if it were left exposed on the bed it needed to be changed because it was contaminated because it could have been dropped on the floor prior. She stated the risk to the resident would be potential infection. She stated the last Inservice was done last month. During an interview on 03/12/2026 at 11:24 a.m. CNA D revealed the nasal cannulas were to be stored in a plastic bag while not in use. She stated the purpose of the plastic bag was to keep the tubbing clean. She stated it was the responsibility of all staff to ensure nasal cannulas were stored properly when not in use. She stated a risk to the resident would be potential infection. She stated the last Inservice was in February. Review of facility policy titled Oxygen Administration not dated read in part under goals section The resident will be free from infection .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 dining rooms reviewed.- 1 living cockroach was in the dining room.-The facility failed to dispose of 1 dead cockroach in the dining room.-The facility failed to dispose of 5 dead cockroaches in the Air Conditioning unit room.This failure placed residents at risk for a facility wide infestation of cockroaches. Findings include:During an observation on 3/11/2026 at 11:05 AM, a live cockroach was discovered in the dining room and was acknowledged by the Activities Assistant. A dead cockroach was found between the wall and the furniture table in the dining room near the air conditioning unit. Inside the air conditioning unit room, 5 additional dead cockroaches were found to the right of the doorway. Activities Assistant proceeded to pass out coffee and stepped over the cockroach at 11:28 AM. Residents sitting in the dining room exterminated the cockroach at 11:37 AM and was left at the table side by the Activities Assistant.During an interview on 3/12/2026 at 8:06 AM with LVN J, she stated she would kill a cockroach immediately, apply gloves, discard of the remains, and wash hands afterward. She stated this needed to be done immediately to prevent the cockroach from escaping and contacting residents. She stated she would notify maintenance immediately after the incident to contact pest control. She stated she had only 1 previous interaction with a cockroach on her floor. She stated she had not received any complaints about cockroaches in residents' rooms.During an interview on 3/12/2026 at 8:39 AM with the Maintenance Supervisor, he stated the facility had a contract with a company that was self-automated to spray poison in the facility once a month. He stated the contracted pest control treated the whole facility and all floors. He stated he was not aware of any complaints from staff or residents regarding cockroaches. He stated if he was aware about a live cockroach he would contact the pest control immediately. He stated he was not notified about the cockroach in the dining room on 3/11/2026 by staff or residents. He stated the facility did not have a policy for staff to exterminate a live cockroach and suggested it would be instinct to kill and dispose of a cockroach. He stated it affected residents because it could potentially cross contaminate food.During an interview on 3/12/2026 at 11:27 AM with the Activities Assistant she stated she advised the HR Coordinator to notify housekeeping to pick up the dead cockroach and disinfect the floor. She identified the residents had killed the cockroach. She stated she notified the HR Coordinator to notify housekeeping so that the area could be disinfected. She stated the cockroach was not a little one associated with cleanliness but the big dark ones associated with water and plumbing. She stated she had a phobia of cockroaches and therefore did not exterminate it herself for the 32-minute observation. She stated pest control came every 3 months to apply poison around the entire facility to deter pests. She stated she suspected the cockroaches were coming from the air-conditioning room. She denied notifying the Maintenance Supervisor of this suspicion. She stated it affected residents because it was an infection control issue, residents could be scared of cockroaches, and that cockroaches could potentially look for food and water throughout the facility. She stated it was housekeeping's responsibility to contact and schedule pest control services. She stated she had never received training on pest control.During an interview on 3/12/2026 at 12:23 PM with the administrator, she stated she was notified about the live cockroach in the dining room by the HR coordinator via group chat. She stated that pest control services came monthly to apply poison as this was an automatic scheduled routine the facility had in place. She stated it was her expectation for staff to kill the cockroach immediately, dispose of it, and document in the pest control book near the receptionist desk. She stated staff could notify any other department head or immediate supervisor about pest problems. She identified herself, the Maintenance Supervisor, and the Receptionist were staff members who could contact pest control to schedule an urgent service apart from their monthly visit. She stated it affected residents because cockroaches carried diseases, presented a health concern, and could potentially create an infestation. She stated there was not a (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy in place that pertained to staff handling live pests.During an interview on 3/12/2026 at 1:40 PM with the DON, she stated she had not been notified by residents or staff about an increased number of cockroaches. She stated pest control came monthly on an automated scheduling system, and pest control binders were located at the receptionist and nurses' stations. She stated any staff member could notify pest control to visit the facility and apply poison and added that it was usually the Maintenance supervisor who organized this service. She stated the steps staff should take when dealing with a cockroach was to remove it from the area immediately, practice hand hygiene after, and document it in the pest control binder. She stated staff needed to report it to their immediate supervisor or the Maintenance supervisor. She stated it affected residents by making them feel bothered at the site of a cockroach. She stated she had not provided an in-service or training to staff on pest control.Record review of the facility's invoices from the pest control company read in part for service date on: 6/18/2025, 7/15/2025, 8/19/2025, 9/5/2025, 10/9/2025, 10/24/2025, 11/7/2025, 12/11/2025, 12/31/2025, 1/8/2026, 2/2/2026, and 3/12/2026 target pest: American cockroach and German cockroach .Record review of the facility's policy titled Insect and Rodent Control dated 2012 read in part, The facility will maintain an effective pest control program in order to provide an insect free and vermin free food service department.ProcedureArrangements are made with a reputable company for regular spraying for insects which includes rodent control when required.Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes structurally maintained walls, baseboard, etc. To prevent entrance access of insects and rodents.Sanitation of facility will be maintained per other stated policies to prevent food sources, breeding places, etc. for insects or rodents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview the facility failed to ensure the residents had the right to examine the results of the most recent survey of the facility and the facility failed to post the results of the most recent survey in a place that is readily accessible to residents, family members, legal representatives of residents, and the public for 1 of 1 survey results binder reviewed.The facility failed to ensure the annual survey results binder was accessible for residents, family members, and staff on 03/11/2026This failure placed residents, family members, and legal representatives of the residents at risk of not being informed the facility's survey and investigation results.Findings included:During an observation conducted on 03/11/2026 from 11:27 AM to 11:55 AM the annual survey results binder was not locatable in an easily accessible area on the ground floor, 2nd floor, and 3rd floor. At 11:56 AM it was observed The Administrator was placing the annual survey results binder in the receptionist desk area.During an interview on 03/11/2026 at 11:57 AM with the Administrator, she stated the annual survey results binder was on her bookshelf inside the administrator's office before she placed it in the receptionist desk area. She stated the binder needed to be placed in an easy access area without the need to ask for it. She stated the bookshelf inside The Administrator's office was not an easily accessible placement for the binder. She stated Resident #51 had wandering behaviors and was known for reorganizing office supplies around the reception desk and added she did not want to potentially lose pages from the annual survey results binder. She added that she will have to review the binder everyday and print out new pages to compensate those misplaced by Resident #51. She stated the binder could be provided upon request and noted there was a print out posting on the cork board across from the ground floor restrooms. She stated residents and visitors should not have to ask for it. She stated it put residents and visitors at risk of not having access to it and added it could be requested and it would be provided. She stated residents and visitors would not have readily access to see past survey results and corrections made by the facility. She stated staff was trained upon orientation from hire on locating the annual survey results binder.During an interview on 3/11/2026 at 12:13 PM with the Receptionist, she stated she had been working at the facility for a month and did not receive training or knowledge about the annual survey results binder. She stated she did not know where it needed to be placed in the facility. She stated if a resident or visitor asked for the survey results binder, she would look in her general area or ask for help from the HR coordinator and the Administrator. She stated she was not sure if it was a resident's right to have access to it. She stated no staff member, resident, or visitor had asked her for the survey results binder before. She stated she did not know how it affected residents and visitors if they did not have access to the survey results binder. She identified the Administrator as the individual responsible for updating the contents of the binder and placing it in an accessible location.During an interview on 03/11/2026 at 12:21 PM with LVN G, he stated the annual survey results binder was in the receptionist desk area. He stated if it was in the Administrator's office it would be a problem for accessibility because it would require assistance from staff to locate the survey results binder. He stated it should always be accessible for residents and visitors. He identified the administrator would be responsible for maintaining the contents of the binder and placing it in an accessible location. He stated the binder contained important information on the building, findings from State investigators, and provided facility corrections taken. He stated it affected residents by limiting access to the information inside the binder. He stated it was a resident's right to have access to it. He stated the last in service was in October or November 2025 on locating the survey results binder.During an interview on 03/12/2026 at 8:15 AM with CNA H, he stated the results to the annual survey could be in the office of the DON or the Administrator. He stated no residents or family members had asked him where to find the survey results binder. He stated it was a resident's right to obtain the information, but the facility had to be sure they were not providing confidential information. He stated he received (continued on next page)

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	03/12/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	training on locating the binder but cannot recall when. He stated he did not know the exact location of the binder, but he could ask supervisors where it was and they could assist him with locating it. During a confidential group interview on 3/12/2026 at 10:15 AM 10 out of 10 residents denied knowing where to locate the annual survey results binder and denied know the significance of the contents of the survey results binder.A policy pertaining to survey binder results was requested from the DON at end of day on 3/11/2026; the facility did not provide such policy.