STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455895	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for four (Residents #1, #2, #3 and #4) of 13 residents reviewed for confidentiality of records. The facility failed to ensure LVN A did not leave Residents #1, #2, #3, #4's medication blister packs on top of an unattended Medication cart while she was in Resident #4's room with the door closed. This failure could place residents at risk of having their medical information exposed causing HIPAA violations with their personal information being known to other residents and visitors, resulting in embarrassment, frustration, and decreased psycho-social well-being. The findings included: Observation on 12/05/24 at 11:37 am to 11:46 am, Residents #1, #2, #3 and #4's medication blister cards were on top of and unattended medication cart. It was in front of Resident #4's room and the door was closed. Record review of Resident #1's December 2024 MAR Printed 12/05/24 revealed, Letrozole Oral Tablet 2.5 MG (Letrozole) Give 1 tablet by mouth one time a day for breast cancer. Record review of Resident #2's December 2024 MAR printed 12/05/24 revealed, Amlodipine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for Hypertension HOLD IF SBP (systolic blood pressure) IS >100 OR HR (Heart Rate) >60. Record review of Resident #3's December 2024 MAR printed 12/05/24 revealed, Citalopram Hydrobromide Oral Tablet 20 MG Citalopram Hydrobromide) Give 0.5 tablet by mouth in the morning for depression. Record review of Resident #4's December 2024 MAR printed 12/05/24 revealed, Levetiracetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet via G-Tube one time a day for seizure. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/05/24 at 11:47 am, LVN A stated she was getting ready to shred the resident's blister packs that were empty but she was rolling the medication cart down the hall and it looked like Resident #4 was about to fall out of bed. She stated she walked away from her medication cart and repositioned him while four residents medication blister packs were on top of the medication cart. She stated the blister pack labels showed Resident #1 was taking Letrozole 2.5 mg for breast cancer and Resident #2 took amlodipine 5 mg for blood pressure. She stated Resident #3 took citalopram 20 mg, for depression and Resident #4 took Keppra (Levetiracetam) 5 mg for seizures. She stated leaving blister packs unsecured could cause somebody to easily see what type of medications the residents took. She stated she had just come from room [ROOM NUMBER] and put the empty blister packs on top of the medication cart. She stated she should have put the blister packs in the medication cart until she was able to get to the shredder box at the nurses station, then taken them out to dispose. She stated she was wrong for leaving the blister packs on the medication cart and added she had a HIPAA training about two or three weeks ago. She stated the residents blister packs had the resident's first and last names, name of medication, dosage and for what the medication was taken. She stated for now on she would wait until she was in the area of the shredder box before taking the blister packs out. She stated leaving the resident's blister packs out and unattended could lead to somebody getting their information and aware of what types of medications they were on and for what they were taking them. Interview on 12/05/24 at 5:26 pm, LVN B stated when the resident's blister packs were empty, they needed to tear the tops of off, because the resident's name were on them. He stated they did that because of the privacy of the patient rights because the blister packs had the resident's names and everything on them. He stated somebody could get the residents information and it was best to lock the empty blister packs in the med cart until they have time to take them to the shredder. Interview on 12/06/24 at 2:54 pm, ADON C stated the nurses were supposed tear off the top part of the blister pack and put into the shredder and the bottom part went into the trash. She stated the LVN A situation the blister packs were turned over, faced down, so the patient info was not disclosed. She stated LVN A was on her way to shred those and stopped to see what was going on to help a resident who was about to fall. She stated LVN A was covered by HIPAA with the blister packs being turned face down and was all right to do that because she had an emergency. She stated she did not think she needed to secure the blister packs in the medication cart because they were okay face down. She stated the blister packs had the resident's names, medication name, dosage, dr name and some say what the diagnosed reason to take the medications. She stated the blister packs could cause a privacy issue if someone picked them up and whatever was on the card could be disclosed. Interview on 12/06/24 at 5:41 pm, the DON stated the empty blister packs should go in a drawer of the med cart and as long as the nurse/med aid was with the med cart it's okay to have the empty blister packs upside down. She stated if the nurse or medication aide was away from the med cart they were supposed to lock the blister packs in med cart before the med cart was moved. She stated leaving a med cart with empty blister packs could be a HIPAA violation because anyone could touch them if the nurse/med aide was not at the med cart. She stated she was not aware LVN A closed Resident #4's room door with the med cart unattended with the four blister packs on the med cart. She stated the blister packs had the resident's names, medication name, date of birth, and diagnoses. She stated they definitely needed to Inservice train the staff about not leaving blister packs on the med carts unattended. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/06/24 6:51 pm, the Administrator stated she was notified yesterday LVN A was going to shred the resident's blister pack and saw her resident was close to falling out of bed so she ran into the room. She stated being told Resident #4 looked like he was about to fall. She stated LVN A_ could have put the empty blister packs in the med cart before she moved the med cart to prevent them from being left unattended. She stated the blister packs had the resident's name, medication name and date of birth. She stated they have had HIPAA trainings yesterday and had a 1:1 verbal warning with LVN A about HIPPAA. She stated the DON was responsible for ensuring staff following HIPAA procedure and unattended med carts with blister packs on top of them could result in other people finding out protected information about the residents. Record review of the Facility's Training dated 12/05/24 by Trainer ADON C revealed, HIPAA/PHI: 1. Never leave items containing (PHI) unattended. 2. Keep empty medication cards and/or containers inside of the medication cart until you are ready to discard them. 3. If you are called away from your cart for any emergency be sure to place the medication cards back into the med cart and lock it. 4. Turning the medication cards face down is not acceptable because anyone can turn them over and have access to (PHI). 5. Discard items containing (PHI) in the appropriate shred box/container. Brief evaluation: I have been educated/counseled on HIPAA rules and proper storage and disposal of items containing (PHI). Record review of the Facility's Resident Right policy undated revealed, Privacy and confidentiality - The resident has the right to personal privacy and confidentiality of his or her personal and medical records .3. The resident has the right to secure and confidential personal and medical records.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record reviews the facility failed to have housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for one (Hall 300) of three halls and five residents (Residents #2, #5, #6, #7 and #8) of 13 residents reviewed for safe clean environment. 1.The facility failed to ensure the housekeeping and nursing departments cleaned the Sit to stand mechanical lift on the 300 hall. 2. The facility failed to ensure Resident #2's bed frame, G-tube machine, wall, and light fixture was thoroughly cleaned and repaired a large hole in the wall next to the headboard of her bed. 3.The facility failed to ensure the housekeeping and nursing departments cleaned Residents #5, #6, #7, # 8's wheelchairs. 4. The facility failed to ensure Resident #8's room was cleaned properly and free from dust and debris particles. These failures could place residents at risk having a feeling of low self-esteem, respiratory and stomach issues and injury due inhaling dust, debris, and sheetrock, resulting in a decline in their psycho-social well-being. Findings included: 1)Observation of the 300 hall's sit to stand transfer assistance machine located against the wall of Resident #2's room revealed, several layers of white and greyish particles of dust and debris on the bottom pan of the lift and the arms of the lift. 2)Observation on 12/06/24 at 8:52 am, Resident #2 was nonverbal and lying in bed. There was two beige colored splash stains on her G-tube machine and smear marks around the power button. A beige colored splash stain was on the left side of the brown overhead light and the right side of the black bed frame had a mixture of whitish splash stains and whitish and greyish dust and debris on it. There was dried paint along the right side of the headboard. Close to the right side of the bed frame, her tannish colored wall had a very large hole that was approximately four inches in diameter. There was several chunks of sheet rock and white paint and netting around the hole and the inside of the wall was visibly seen. Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS score of 0 (severe cognitive impairment) with use of a wheelchair. She was totally dependent with all ADL Care and always incontinent with bladder and bowel. She had medical complex conditions, with diagnoses of anemia, HTN, hypernatremia, Alzheimer's, persistent vegetative state. And use of a (G-tube) feeding tube. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3)Observation on 12/04/24 at 1:26 pm revealed, of Resident #5's black wheelchair appeared to have several layers of greyish dust and whitish colored debris on both footrests, both armrest, around his seat cushion and the back of the wheelchair and all four wheels. Record review of Resident #5's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old male who admitted on [DATE] with a BIMS Score of 15 (no cognitive impairment) and use of motorized wheelchair. Partial to moderate assist with ADL care and Occasionally incontinent with bladder and ostomy care for bowels. He had medically complex conditions, renal insufficiency, septicemia, cerebral palsy, paraplegia, anxiety, depression and bipolar. Interview on 12/04/24 at 1:09 pm, Resident #5 stated he would like to get his wheelchair cleaned and reported it to the AD and DON and it was discussed in the Resident Council Meetings. He stated it would make him feel better with it clean just how someone felt after taking a shower. He stated they used to clean his wheelchair after he took a shower and was not sure when but they stopped cleaning it. He stated he was not sure when the last time he asked to clean his wheelchair, but said it used to be a scheduled wheelchair cleanings done on the 11pm to 7 am shift. He stated he asked the DON and had just stopped asking. 4) Record review of Resident #6's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old with a BIMS Score of 13 (No cognitive impairment) and used a wheelchair. With partial to substantial assist for most ADL care. He was occasionally incontinent with urine and bowels with Medically complex conditions. He was diagnosed with HTN, hypernatremia, aphasia, hemiplegia/hemiparesis, and depression. Interview and observation on 12/04/24 at 2:04 pm, Resident #6 stated he had issues with his wheelchair getting cleaned and that the facility never cleaned it. He stated his FM cleaned it monthly because his wheelchair looked bad and had asked the nurses about cleaning it. He stated the nurses said somebody would clean his wheelchair but they never did and his FM cleaned his wheelchair last month. He stated he stopped bringing it to their attention because he did not feel they would do anything about it and added his wheelchair had not been cleaned in the five years of being at this facility. He stated If the staff cleaned his wheelchair once a month, he would be happy. He stated not getting his wheelchair cleaned made him feel like nothing, like no one cared about cleaning it. He stated he would rather his FM not clean it but he had no other way of getting it cleaned. Resident #6's wheelchair had moderate dust and greyish and whitish debris buildup on the wheels, footrests, and seat area. 5)Observation on 12/06/24 at 4:02 pm of a picture of Resident 7's blue wheelchair was next to the receptionist desk folded up and the back of the seat appeared soiled with a blackish color. The right armrests appeared to have a greyish stick substance on it and there was a whitish debris in several crevices and the metal areas had a light brownish color in some areas. Record review of Resident #7's Annual MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS score of 03 (severely impaired). She used a wheelchair and substantial to Maximal assistance with most ADL care and always incontinent with urine and frequently incontinent with bowels. She had medically complex conditions and diagnoses of HTN, acid Reflux, renal insufficiency, and hyperlipidemia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/04/24 at 11:27 am, a FM stated the staff were supposed to clean the resident's wheelchairs weekly but they were not doing so. She stated Resident #7's wheelchair had food and grime on the seat and armrests. She stated Resident #7 was given another wheelchair that was clean but then she was put back in the old nasty wheelchair. Interview on 12/06/24 at 11:32 am, the Relocation Specialist stated Resident #7 discharged home 11/27/24 and needed to use the Facility's wheelchair because FM left her new wheelchair at home. She stated the nursing home let Resident #7 borrow the Facility wheelchair until she got home. She stated she took the Facility wheelchair back to this Nursing Home and took a picture of it before giving it to the Receptionist. She stated she took the wheelchair picture as proof she dropped it off. 6)Observation on 12/05/24 at 12:35 pm, Resident #8's room had a dark brown three tier cube organizer with several layers of dust and white colored debris. Her black recliner wheelchair appeared dusty with a wheelchair battery and several miscellaneous items on the seat. The black wheelchair appeared very dusty with white speck of white debris or chalk on the seat cushion and both armrests. Record review of Resident #8's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS score of 12 (Mild cognitive impairment). Her diagnoses included respiratory failure, two stage 4 ulcers, and total dependence for all ADL care and Oxygen dependent. Interview on 12/05/24 at 2:10 pm, CNA D stated the CNA's on the nightshift were supposed to clean the resident's wheelchairs. Interview on 12/05/24 at 2:49 pm, LVN E stated the Hoyer lifts should be cleaned daily by whoever used them should clean them afterwards. She stated she noticed the sit to stand lift was dirty and it needed to be cleaned. She stated the CNA's were usually supposed to clean the resident's wheelchairs during the night. Interview on 12/05/24 at 4:07 pm, CNA F stated she was not sure who was supposed to clean the hoyer lifts and had not seen anyone clean the lifts. She stated the 300 hall ADON C, were responsible for ensuring the wheelchairs were cleaned. She stated she was aware the nightshift CNA's had a schedule sheet of all the wheelchairs to clean on the nightshift. Interview on 12/06 at 9:57 am, SW G stated a couple of months ago, the former Administrator H, DON, DOR discussed ways to get the wheelchairs cleaned. She stated they were aware and brainstormed on what could be done and thought about doing a car wash type of setup of rolling the cars through with a power washer. She stated the wheelchair cleanings were scheduled to be done in the evenings while the residents were in bed. Interview on 12/06/24 at 10:51 am, LVN I stated he worked the nightshift and had not seen wheelchairs being cleaned at night and could not remember the last time the CNA's cleaned the wheelchairs. He stated there was no scheduled time the CNA's cleaned the wheelchairs and just when they needed cleaning. He stated he had not noticed any of the resident's wheelchairs were dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/24 at 11:58 am, Medication Aide J stated she worked nights in the locked unit on other halls at times. She stated the wheelchairs were cleaned for the residents in the locked unit but did not clean and resident's wheelchairs on the 300 hall. She stated she was not sure of 300 hall wheelchair cleaning schedule. She stated she was not sure who cleaned the Hoyer lifts and sit to stand lifts. Interview on 12/06/24 at 12:44 pm, CNA K stated he worked the 3:00 pm - 11:00 pm shift and used wet wipes to clean the residents wheelchairs and there was no schedule on when to wash the residents wheelchair. He stated when they looked dirty, he cleaned them. Interview on 12/06/24 at 1:20 pm, the Maintenance Director stated he and the therapy staff washed the wheelchairs pretty regularly. He stated he washed Residents #7 and #8's wheelchairs but was not sure how long ago. He stated he generally cleaned Resident #5's wheelchair when he asked, he cleaned it, probably this last summer He stated maybe wheelchair cleanings was something they should work on doing more of. He stated the Administrator and all staff were responsible with cleaning the wheelchairs. He stated he was not sure if the aides cleaned the wheelchairs at night and would have to ask the DON and ADON C. He stated he had not checked Resident #5's' wheelchair but would go check it out once he completed this interview. He stated they did not have one designated person ensuring the wheelchairs were cleaned and no system in place. He stated the wheelchairs were cleaned only when needed to be cleaned and when requested. He stated the CNA's really needed to keep a lookout on the cleanliness of the wheelchairs. He stated he was open to getting the wheelchair policy and was not sure Resident #6 requested to getting his wheelchair cleaned. He stated he was not aware of the hole in Resident #2's room and which should have been reported for him to repair. He stated he had talked to the staff about making sure they used the maintenance system for reporting repairs and was not sure why that was not done. He stated he received maintenance notifications and also checked the logs 4 -5 times a day and had no notices of holes in Resident #2's room. He stated he just added it to the maintenance care system and he was going to Resident #2's room after this interview to fix it. He stated the CNA's were supposed to clean the Hoyer and standup lifts and he was supposed to check the safety of the machines. He stated he had discussed with the previous Administrator and DON about getting new Hoyer and sit to stand lifts because they do look kind of tattered and worn. He stated he had not mentioned this to the new Administrator because he had a lot of items to repair and was very, very busy. He stated rooms without repairs and not cleaned could cause some types of health issue and could make the resident upset. He stated it could cause a quality-of-life issue with a hole in the resident's room and added no one wanted a huge hole in their room. He stated he did not have a maintenance assist for a very large facility, licensed for 280 beds. He stated he was not aware Resident #8's wheelchair needed to be cleaned. He stated they also had a communication app the department head directors used to report any issues during their champion rounds. He stated none of the directors reported the hole in Resident #2's room and said he was going to talk to the department head who was supposed to do the champion rounds of Resident #2's room. Interview on 12/06/24 at 1:55 pm, Director of Rehabilitation (DOR) stated the wheelchairs were usually cleaned during the night shift and when the residents in therapy and noticed they were dirty they were cleaned. She stated they did not have a system in place to clean them. She stated the nursing department was responsible for cleaning the Hoyer and sit to stand lifts. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/24 at 2:20 pm, Housekeeping Supervisor L stated her housekeeping department, nursing and therapy departments were responsible for cleaning the wheelchairs. She stated they cleaned the wheelchairs in the secured unit about two weeks ago and was not sure when the 300 hall resident's wheelchairs were cleaned. She stated she was not aware of Resident #2's room being dirty with stains and dust and would have to talk to Housekeeper M who was responsible for cleaning Resident #2's room. She stated the housekeepers cleaned the resident's room daily but sometimes the nursing staff change the formula and spilled it on the floor, bed and everywhere. She stated she had nine housekeepers that worked from 8:00 am - 4:00 pm and 7:00 am - 3:00 pm and 2 housekeepers worked from 2:00 pm to 10:00 pm. She stated she had not noticed Residents #5, #6 #8's wheelchairs were dirty and if she did, she would assist the nursing department with cleaning them. She stated at first, she thought it was the nursing departments responsibility to clean the Hoyer and sit to stand lifts, but the housekeeping department was responsible for cleaning them daily. She stated she was not sure when the last time the Hoyer and sit to stand lifts were cleaned but they were cleaned today because they looked bad. She stated she notified her housekeeping staff the lifts had a lot of debris on them and she said cleaning the lifts would be added to the list to be daily. She stated she was going to monitor to ensure they were cleaned and was not sure how she was going to and was in the process of figuring it out. She stated the residents could get sick and contract something because it was an infection control issue. She stated the housekeeping department was responsible for cleaning the bed frames, mattresses, and light fixtures. She stated the staff needed to ensure the nurses was present to clean the G-tube machines. Interview on 12/06/24 at 2:54 pm, ADON C stated she had not ever seen the residents' wheelchairs dirty and there were no requests for them to be cleaned. She stated the nightshift CNAs were supposed to clean them but they did not have a schedule on when the wheelchairs were to be cleaned. She stated the CNA's were supposed to check the resident's wheelchairs while doing their rounds and if they were filthy, they needed to take those to the shower room for cleaning. She stated she was not sure when Residents #6 and #7 and #8 wheelchairs were cleaned and was unaware Resident #2 had a hole in her wall. She stated she was not sure Resident #2 had G-tube formula stains on the bed and other areas and added the housekeeping department was responsible for cleaning the Hoyer and sit to stand lifts. She stated with the Department head did the champion rounds they were supposed to check the resident DME and wheelchairs for cleanliness. She stated it was an infection control issue with the dirt or any stains not being cleaned up and depending on the situation it could be a hazard for the lift had dust buildup that could cause it to malfunction. She stated her expectation was to be vigilant of repairs needed and they had a scan code to report maintenance repairs. She stated she was not sure if they had a wheelchair cleaning policy and would go to check. Interview on 12/06/24 at 4:40 pm, Receptionist N stated after Resident #7 discharged on [DATE], her old wheelchair was returned a few hours later from the relocation specialist. She stated Resident #7's wheelchair that was returned had a problem with the cleanliness of it. She stated the wheelchair did not appear to be very clean; the seat part was dirty with dried up food that was tannish in color with food dried stains. She stated she wondered why the wheelchair had not been cleaned , then she notified the therapy department to pick up the wheelchair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/24 at 5:41 pm, the DON stated the 11:00 pm - 7:00 am staff were to clean so many wheelchairs per night and did not think they had a monitoring system in place or checklist because it was something she needed to add to her checklist. She stated ADON C was responsible for ensuring the wheelchairs were cleaned on the 300 hall and said she did not think they had a wheelchair cleaning policy. She stated the nurses and housekeeper checked and cleaned them as needed. She stated she asked the housekeepers to clean the lifts and had not noticed they were dirty. She stated they had a QR code to report maintenance requests, champion round checks and meetings and no one brought up Resident #2 had a hole in her wall. She stated the hole in her wall needed to be repaired immediately because it was a good way for pest to come into the resident's room. She stated it was not conducive to the looks on the resident's environment. Interview on 12/06/24 at 6:51 pm, the Administrator stated she was not aware of the hole in Resident #2's wall or that she had dried formula stains on her bed frame and G-tube machine. She stated the G-tubes were supposed to be checked daily by nursing and the housekeepers had particular days to clean the bed frames. She stated if a nurse splashed formula on the G-tube machine they should clean them and the housekeepers should clean the light fixtures. She stated if any department head saw a dirty room, they should report for it for getting cleaned. She stated they had a really great system with scanning the QR codes at the nurses station, for maintenance requests and the Maintenance Director reviewed the requests to ensure things were fixed. She stated the hole in Resident #2's room must have just occurred today because no one had reported it yet. She stated after the Maintenance Director was informed about the hole in the wall, he temporarily fixed it with a closure covering the hole. She stated the maintenance director and herself was responsible for ensuring the maintenance repairs were completed. She stated depending on what was broken could result in resident injury and just overall cause safety issues could impair them from having a homelike environment. She stated wall holes could cause critters to possibly comes thru the wall. She stated she had not noticed any dirty wheelchairs and there had not been any complaints about them being dirty. She stated they did not have a plan in place or schedule to clean the wheelchairs but she was implementing a plan for the night shift staff to start cleaning them. She stated the plan was for them to clean the A bed residents one day and B bed residents the next day. She stated she was responsible for ensuring the residents wheelchairs were cleaned, they did not have a policy on cleaning wheelchairs, but today she bought the scrubbers and a checklist will be created to ensure the wheelchairs were cleaned. She stated the staff were trained on what to do and documenting wheelchair cleanings. She stated they did not have a maintenance and housekeeping policy. Record review of Facility's Maintenance repair log sheets did not reveal any requests for Resident #2's hole in her wall to get fixed. Record review of the Facility's Training on Equipment Cleaning dated 12/05/24 revealed, 1. Wheelchairs are to be washed and cleaned by the CNA's on the 11 - 7 shift. 2. Charge nurse will assign wheelchairs that need to be wash to [sic] the CNA's 3. All equipment must be properly cleaned and disinfected between each resident before use, 4. Be sure that Hoyer lift, lifts are cleaned and free of debris and notify housekeeping if you notice Hoyer lifts that need to be cleaned. Record review of the facility's Housekeeping policy was requested from the Administrator on 12/06/24 at 4:37 pm and not provided and the Administrator stated they did not have one. Record review of the facility's Maintenance policy was requested from the Administrator on 12/06/24 at 4:37 pm and not provided and the Administrator stated they did not have one. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facility Resident's rights undated revealed, Resident Rights: 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. Safe environment - The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide 1. A safe, clean comfortable, and homelike environment .2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #8) of 13 residents reviewed for infection control. The facility failed to ensure staff did not leave an unwrapped piston syringe (used to withdraw bodily fluids) to flush Resident #8's urinary catheter, was left on her dresser with her personal belonging around it. This failure could place residents at risk of getting sick with infections due to cross contamination which could result in a change in condition and decreased psycho-social well-being. Findings included: Observation on 12/05/24 at 12:14 pm revealed, Resident #8 was on EBP for a urinary catheter and wound on her sacral. There was a piston syringe and pack of gauze dressing on her dresser next to a basket of magazines and a toothbrush. There was snacks on the other end of the dresser. Record review of Resident #8's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS score of 12 (Mild cognitive impairment). Her diagnoses included respiratory failure, two stage 4 ulcers, and total dependence for all ADL care and Oxygen dependent. Record review of Resident #8's Order Summary Report printed 12/05/24 revealed, Flush foley with 30cc NS (Normal Saline) everyday PRN (as needed) for maintain catheter patency Verbal Active 01/20/2024. Record review of Resident #8's December 2024's TAR revealed no initials documented for, Flush foley with 30cc NS (Normal Saline) everyday PRN (as needed) for maintain catheter patency. Record review of Resident #8's December 2024's TAR for Catheter Care revealed on 12/04/24: LVN E, LVN O and RN P signed off completing tasks, Empty foley bag every shift and record urine output every shift. Interview and Observation on 12/05/24 at 12:39 pm, ADON C stated she came to assist Resident #8 then LVN E walked into Resident #8's room and the HHSC surveyor asked why was the catheter Syringe and a pack of gauge dressing on Resident #8's dresser where her personal belongings were. Then LVN E stated she was not sure why the piston syringe and gauze was on Resident #8's dresser and immediately grabbed them and threw them into the trash and washed her hands. LVN E stated she was not sure who left those items in the resident's room and said the Piston syringe was used for flushing her urinary catheter. Interview on 12/05/24 at 12:49 pm, ADON C stated she had a concern about the syringe being left in Resident #8's room that she was going to address with the nursing staff about not doing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/05/24 at 1:21 pm, the Administrator stated she was not aware Resident #8's catheter syringe was on the dresser and it should not be in her room like that. She stated it was an infection control issue and she was going to start a training on it. She stated she would find out the last person who did Resident #8's catheter flush. Interview on 12/05/24 at 2:49 pm, LVN E stated the nurses did the catheter flushes once per day and the catheter was supposed to be thrown away. She stated she had not ever seen syringes on Resident #8's dresser before and stated leaving unwrapped syringes in the resident's rooms could lead to potential infections if they were used again. Interview on 12/05/24 at 5:26 pm, LVN B stated it was not hygienic to have a catheter syringe on the dresser because it possibly had urine in it and if a resident were confused, they could use the catheter and play with it and get an infection. Interview on 12/06/24 at 2:54 pm, ADON C stated Resident #8 was on EBP for chronic bacteria of the urine and a catheter and had a recently healed wound. She stated they were not able to determine who left the piston syringe and some kind of kit on her dresser. She stated the piston syringe was used to flush her foley catheter and once the syringe was used, they should throw it away because of the infection control issue could cause UTI and other infections. She stated they have been doing Infection control trainings with the nurses to ensure the catheter syringes were discarded after every use. She stated all of the nursing staff were responsible for disposing syringes after catheter use. She stated she was overall responsible to ensure the staff were following their infection control policy and procedure. She stated she expected the nurses followed their infection control policy. Interview on 12/06/24 at 5:41 pm, the DON stated the nurses were responsible for flushing out the resident's catheter lines. She stated there were no issues with flushing the resident's catheters, they were still trying to find out who left the catheter on the residents dresser. She stated not disposing the piston syringes could lead to infection control and become a catalyst to another infection. She stated Resident #8 already had chronic infections and saw a urologist for her suprapubic catheter and on EBP because of her catheter usage and chronic infections. She stated they needed to immediately investigate to see who left the syringe on the dresser to ensure no CNA's did more than they were supposed to do. She stated she wanted to ensure the staff were trained on what to do with the supplies taken to the resident's room and procedures. She stated she also wanted to do a return demonstration on catheter flushing and said the nurses themselves were responsible for ensuring the syringes were thrown out. She stated their department head who did Champion rounds in Resident #8's room should have seen the syringe and reported it to the ADON and DON. She stated ADON C was responsible for making rounds to ensure syringes were not left in the resident's rooms. Interview on 12/06/24 at 6:51 pm, the Administrator stated she initiated trainings with the staff about their syringe procedure and catheter flushing steps to take afterwards. She stated they were doing trainings on infection control and competency checkoffs and was not sure but was told LVN A left the syringe on Resident #8's dresser. She stated leaving syringes on the resident's dressers could cause illness and infection if the catheters were not disposed of after use. She stated ADON C, DON and herself was responsible for ensuring the staff followed their infection control policy. She stated they would continue to do champion rounds to report issues if they saw unwrapped syringes on the resident's dressers. (continued on next page)

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	455895	A. Building B. Wing	12/06/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's trainings on Storage dated 12/05/24 revealed, Storage and disposal of piston syringes: For catheter flushes, piston syringes must be discarded after each us [sic] to avoid infections. Record review of the facility Catheter Care policy revised 02/13/07 revealed, Catheter Care: 1. Determine if the resident's urine level has increased. If the level stays the same, or increases rapidly, report it to your supervisor. Record review of the facility's Infection control policy dated Infection Control Policy & Procedure Manual 2019 UPDATED 3/2024 revealed, Infection Control Plan: Overview - Infection Control The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Infection Control Program The facility will establish an Infection Control Program under which it -Investigates, controls, and prevents infections in the facility. Decides what procedures, such as isolation, should be applied to an individual resident; and Maintains a record of incidents and corrective actions related to infections.