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	01/23/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident's property for one (Resident #1) of five residents reviewed for injuries of unknown origin. The facility staff failed to report an injury of unknown origin to the abuse and neglect coordinator when Resident #1 sustained a large bruise to her right and left eyes and laceration to her right eyebrow. This failure could place the residents at risk for further potential abuse due to unreported and uninvestigated allegations of abuse, neglect, and injuries of unknown origin. Findings included: Record review of Resident #1's Face Sheet dated 01/23/25 reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's active diagnoses included Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions), dementia with mood disturbance (a decline in cognitive function with behavioral disturbances due to the progressive deterioration of brain cells), muscle weakness, dysphagia (difficulty in swallowing food or liquid), lack of coordination, type 1 diabetes (a chronic disease that occurs when the body's immune system destroys the insulin-producing cells in the pancreas), malnutrition, schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and repeated falls. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed her BIMS score was 05, which indicated severe cognitive impairment. She had unclear speech and sometimes understood others. Resident #1 had no signs or symptoms of delirium, no negative mood issues, no potential indicators of psychosis, no verbal or physically aggressive behaviors, and no rejection of care. Resident #1's assessment reflected she wandered daily. Resident #1 had no range of motion of issues and used a wheelchair for mobility and she required substantial/maximum assistance for activities of daily living. Resident #1 weighed 91 pounds and was five foot three inches. (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 01/23/2025
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's care plan dated 06/27/24 and last revised on 01/17/25 reflected she was at risk for falls due to her Huntington's diagnosis and had an unwitnessed fall on 01/13/25. She was also at risk for wandering and as an intervention, she was placed in the facility's secured unit. The care plan also reflected Resident #1 had a bruise on her left eye and cheek (updated on 12/18/24). Interventions included to identify potential causative factors and eliminate/resolve, when possible, monitor location/size of the bruise, and report any abnormalities to the MD. Record review of Resident #1's nursing progress notes related to her injuries dated 01/13/25 revealed the resident had an injury of unknown origin with a hematoma to the back of her head and a bruise to the left eyebrow. The progress note further revealed at Resident #1 was unable to state what happened but the resident also said she fell . Resident #1 was sent to the ER and returned later that day with an order for a prophylaxis antibiotic for a hematoma to the back of her head. Record review of the facility's incident reports to HHSC, related to Resident #1, revealed the ADM submitted a facility incident related to an injury of unknown origin for the injury to the back of Resident #1's head that was discovered on 01/03/25 and completed an investigation according to HHSC regulations. Record review of a nursing progress notes five days later on 01/18/25, written by LVN A, reflected Resident #1 had a change in condition, stating in part, Writer observed resident being minimally responsive while lying in bed. VS 97/75/72 RR15 T97.6 O2 95 ra. RP notified of condition and stated that she was ok with res being admitted to hospital for further tx. PA notified and voiced understanding. DON notified as well. Res will be sent to [Hospital Name]. ER dept was called x2 and call was never picked up to give report. Record review of Resident #1's most recent weekly skin assessment completed on 01/18/24 by LVN A, at her change of condition, reflected Resident #1 had bruising present on her face and eyes, as well as skin abrasions present on her bilateral knees, buttocks, hips, and right shoulder. A skin assessment completed prior to that on 01/13/24 by ADON B revealed Resident #1 had a bruise on her left eyebrow and a skin tear on her posterior head, an injury which had already been documented and investigated by the facility. Record review of the facility incident reports from 01/13/25 through 01/22/24 reflected no incident report related to Resident #1's bruising and injuries documented in the skin assessment on 01/18/24. An interview with LVN F on 01/22/25 at 12:10 PM revealed she was the morning charge nurse for Resident #1 during the weekdays. She last remembered seeing her the day before she was sent to the ER for a change of condition (01/17/24) and did not recall seeing any bruises on her face or body and no black eyes. She stated the bruise she did see on Resident #1 was a small one on her left temple. LVN F stated if she saw a change in a resident's skin, she would notify the ADM, the DON, the MD, the wound care nurse, the RP, and do an incident report so we are all on the same page. LVN F stated Resident #1 was not self-injurious but did walk with an unsteady gait and walked independently . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with CNA G on 01/22/25 at 12:51 PM revealed she worked on the secured unit and although she was not Resident #1's assigned CNA for the past two weeks, she still saw her in the secured unit. She did not see any bruises or black eyes on her face or any injuries on her body. CNA G stated she had not seen Resident #1 fall and had not heard of any unwitnessed falls, but said the resident was very wobbly in her gait. An interview with ADON B on 01/22/25 at 2:51 PM revealed potential indicators of physical abuse could be marks, any type of bruising, discoloration, scratches, and an injury of unknown origin. An injury of unknown origin was a bruise that if we see what didn't see what happened or cannot identify if blood work drawn, or even a fracture, if the resident fell of if it was pathological. ADON B stated a suspicious injury would be if she observed a bruise on the groin or buttock area and upper arm, or if the resident had bruises shaped like finger marks or bruises on the eye. If a resident had an injury of unknown origin, ADON B stated the facility would try to investigate what happened and would notify the administrator, the DON, the RP, But a lot of times you don't know because they bump into each other and things. ADON B stated when an injury of unknown origin was discovered, the charge nurse was supposed to be notified first, then that charge nurse would contact the administrator next since it was an injury of unknown origin and then notify the rest of the nursing management team. ADON B stated the potential harm of not investigating a resident with suspicious bruises or injuries was that one would not be able to tell if it was caused by another resident or staff member, And you are putting other residents at risk. ADON B stated she saw a photo on the DON's phone, that LVN A sent the DON over the weekend on 01/18/25, when Resident #1 was sent to the ER of her back abrasion injuries but did not see any photos of her face. ADON B stated Resident #1 was ambulatory and could move around on her own but had a recent change in her gait and was having more difficulty getting around and had more jerky movements. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 01/22/25 at 3:20 PM revealed that LVN A sent her a text on Saturday 01/18/25 stating he saw some marks on Resident #1 that looked like scratches and bruising on the boney parts of her body. LVN A wanted to know if the DON knew where those marks came from and that the resident was not acting like herself. LVN A told her that Resident #1 was not moving around much, just lying on the bed, not responsive to verbal stimuli but to painful stimuli, and inquired if the facility had gotten the approval to refer the resident to hospice. The DON stated she told LVN A to send Resident #1 to the ER since she was a full code. The DON stated Resident #1 fell quite often and she already had an area on the back of her head and left eyebrow from an unwitnessed fall a week prior which had been called into HHSC as a self-reported incident. The DON stated potential indicators of physical abuse could be bruising of unknown origin, skin tears of unknown origin, or a resident drawing back from people. The DON stated she did not observe any of those indicators with Resident #1. The DON stated an injury of unknown origin was one that could not be determined as to what happened and one could be investigated to see what happened but could never be definitive. The DON stated a suspicious injury was one that had a shape to it such as a finger, palm, or hand shaped bruise, a grabbing bruise, as well as multiple skin tears and bruising when the staff never see the resident bump into anything. If a resident had an injury of unknown origin or any bruises that could not be explained, the DON stated, The immediate thing is to make sure that person is safe, call me and then call [ADM] as the abuse/neglect coordinator in case we go into that (reporting to HHSC). We start the investigation and tell the nurse to do a head-to-toe assessment and to call the doctor depending on the injury. If the resident is sent out, the (charge) nurse needs to talk to me. If they hit their head, I want skull x-rays, hip x-rays, ankle x-rays and so forth since this is an older generation. The DON stated it was not up to anyone to determine if an injury or bruise was suspicious or not, it was to be reported to the nurse and then the nurse was to report it to the DON and the DON and ADM will look into it. The DON stated the potential harm of not investigating a resident with injuries of unknown origin including bruises were that the resident could potentially continue to be abused if that was occurring. The DON stated she felt when Resident #1 flails her hands, she could not control where her hands hit her body due to her diagnosis of Huntington's disease, so she did not know if that caused the current injuries on her face. She felt that Resident #1's injury to the back of the head came from an unwitnessed fall as well as a black eye the resident had in mid-December 2024 when she tore a frame picture off the wall in the secured unit and hit her eye with it. The DON stated when LVN A texted her, he did not mention the bruises on Resident #1's face. The DON stated she discovered that today (01/23/25) when she was reviewing Resident #1's last skin assessment, completed the day she was sent to the ER. She said the skin assessment completed by LVN A did reflect Resident #1 had bruising on her face and other injuries but there was no other description or sizing/measurements of the bruises. The DON stated her expectation was that she should have been notified when the first staff person recognized the fresh bruising to Resident #1's face and abrasions to her back. The DON stated staff should have numerous times to observe any resident injuries, such as when getting a resident up for breakfast, showering a resident and dressing them, They should have seen it. At any one of those times, it was an opportunity to see the injury and report it. If it didn't happen in the morning or overnight and when was it first noticed? An interview with the ADM on 01/22/25 at 4:01 PM revealed Resident #1 did not have any black eyes or injuries that she had been made aware of. She stated if there were any black eyes or bruises, as the abuse/neglect coordinator, she should have been notified so that an investigation could be initiated. On 01/22/25, after investigator intervention, the facility's ADM initiated a self-reported incident to HHSC and started a provider investigation into Resident #1's injuries of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with MA D on 01/23/25 at 11:52 AM revealed she worked the morning and afternoon shift in the secured unit with Resident #1 on 01/18/25 but was not her main caregiver. MA D stated, I saw her face, like a dark part on the eye, her face looked bruised, but I had to call the nurse (LVN A) to look at her and he said he would call the family because she was not good. MA D described the injury she saw on Resident #1, it was there in the morning, she could not remember which eye, it looked like a black eye. MA D stated she did not know what happened to her eye and that was why when she saw it, she notified LVN A. MA D stated no one rounded with her when she came to work from the overnight shift, so she did not know how Resident #1 got the black eye. MA D stated if there was an injury on a resident, she was supposed to report it and she did, she notified the charge nurse. She stated, Because it wasn't looking fresh, I was thinking maybe something happened during the week, I was going to follow up. MA D stated the abuse/neglect coordinator was the ADM and she was supposed to be notified right away for any concerns and the ADM wanted to be notified about any form of abuse. An interview with CNA E on 01/23/25 at 1:55 PM revealed the last time she remembered seeing Resident #1 was the morning of 01/16/25 when she helped the other CNA on the floor with Resident #1, and they cleaned her in the morning along with the nurse. All three of them saw her and at that time, CNA E stated she remembered seeing an eye injury on Resident #1, but she did not know what happened and could not remember what the injury looked like or where it was. CNA E stated she thought Resident #1's eyes looked black like she had fallen on something or something happened. She showered Resident #1 due to an incontinent episode and did not see any other injuries on her body. CNA E stated Resident #1 did not sleep a lot, liked to walk around all the time and pick things up and enter other people's room uninvited. The staff will tell her to sit down in a chair, but she will eventually get up and start walking, but CNA E had never seen Resident #1 fall. CNA E stated an injury of unknown origin was when a resident was found injured. When that occurred, the staff had to immediately report it to the charge nurse to they could assess and write an incident report. Same thing if a bruise was found on a resident, the charge nurse was to be notified and find out if any staff had already reported it, what happened, and give report to the next shift. If there was no incident in the system, then the current nurse on duty would need to follow up and find out what happened. CNA E stated, Maybe this person got injured and you do not report, something could happen. It is important if someone if injured. CNA E stated, I did not report the black eye on [Resident #1]. I was asking the nurse what happened to [Resident #1] I think I questioned it. But it wasn't something new, it was older, like the skin was becoming dark. When asked who the Abuse and Neglect Coordinator was at the facility, CNA E stated, Now I can't remember. A follow up interview with the ADM and the DON on 01/23/25 at 1:57 PM revealed after looking at photos of Resident #1's facial bruising and back abrasions, the DON felt the one black eye was from the incident where the resident pulled a framed picture off the wall and hit her face. She also felt the resident may have been wearing glasses which could have caused the lighter yellow bruising across the bridge of her nose between her eyes. She said Resident #1 wore glasses, even though her MDS indicated she did not. The DON also felt the bruising could be a symptom of her advancing Huntington's and said spontaneous bruising could occur with the disease process. The DON stated, If I had seen the bruises, I would have reported it to the Abuse/Coordinator, and we would have followed the investigation for the State. The ADM stated she was the one to make the decision on if a resident's injury was suspicious, not the staff, but she must know about it first in order to investigate. The ADM stated staff had been in-serviced on if they see a bruise, not to assume it had been reported and to let someone know, and let me decide from there. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Abuse/Neglect, revised March 2018, reflected, .The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility .; Definition . 12. Injury of Unknown Source any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time; .C. Prevention: . 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee, D. Identification: The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interviews and record review, the facility failed to provide pharmaceutical services (including the procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of five residents reviewed for medications and pharmacy services. The facility failed to take Resident #1's blood pressure and administer her medication in accordance with the physician orders. Resident #1 was administered Propranolol (a beta blocker medication that relaxes blood vessels in the body is used to treat a variety of conditions including high blood pressure) three times a day from 12/01/24 through 01/18/25. The medication was only to be given if her blood pressure was over 110/60. However, there was no documented evidence to indicate her blood pressure was taken in her clinical record to validate the medication needed to be given and did not need to be held. This failure could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and potential for decreased health status, including low and high blood pressure, falls, disorientation and physical discomfort. Findings included: Record review of Resident #1's Face Sheet dated 01/23/25 reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's active diagnoses included hypertension (abnormally high blood pressure that is not the result of a medical condition), Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions), dementia with mood disturbance (a decline in cognitive function with behavioral disturbances due to the progressive deterioration of brain cells), and repeated falls. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed her BIMS score was 05, which indicated severe cognitive impairment. She had unclear speech and sometimes understood others. Resident #1 had no signs or symptoms of delirium, no negative mood issues, no potential indicators of psychosis, no verbal or physically aggressive behaviors, and no rejection of care. Resident #1 had no range of motion of issues and used a wheelchair for mobility and she required substantial/maximum assistance for activities of daily living. Record review of Resident #1's care plan dated 06/27/24 and last revised on 01/17/25 reflected she was at risk for falls due to her Huntington's diagnosis and had an unwitnessed fall on 01/13/25; however, there was no focus area reflected for her hypertension or related interventions. Record review of Resident #1's January 2025 Physician's Orders reflected she was prescribed the beta blocker Propranolol 0.5mg three times a day for a diagnosis of hypertension (Start Date 06/27/24-open ended). The order also reflected, Hold for SBP<110 and DBP <60. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's December 2024 and January 2025 MAR reflected she was administered the medication Propranolol every day she was at the facility from 12/01/24 through 01/18/25 with the exception of twice on 12/19/24 and once on the 12/20/24. The MAR also indicated under the name of the medication that it had parameters to be held if the blood pressure was 110/60. Record review of Resident #1's vital records on the e-chart documented under the Vitals Tab reflected blood pressure readings only on 12/06/24, 12/13/24, 12/20/24, and 12/27/24. There were no blood pressure readings three times a day for Resident #1 from 01/01/25 through 01/18/25. An interview with ADON B on 01/22/25 at 2:51 PM reflected she was in charge of overseeing the secured unit where Resident #1 lived, but all resident blood pressure audits were done by the other two ADONs. ADON B stated if there was an order for blood pressure to be taken prior to giving a medication, then the blood pressure should be taken. If it was not taken or if a resident refused or was moving too much to get an accurate reading, then the staff would need to notify the charge nurse so it could be documented. ADON B stated taking a resident's blood pressure was tied to their vitals parameters and if a medication for hypertension was given and the resident's blood pressure was already low, it could cause the resident to become unresponsive or sustain a fall. ADON B stated the blood pressure entry should be documented on the MAR with the medication. She stated when a MAR was being generated, the person generating it was responsible for ensuring the vitals parameter box was checked in order for it to show up and be placed on the MAR for staff to enter blood pressure readings. An interview with MA D on 01/23/25 at 11:52 AM reflected she worked with Resident #1 the morning of 01/18/25 and worked a double shift from 7AM to 11PM. MA D stated she knew what the medication Propranolol was used for, and she gave it to Resident #1 routinely and crushed it into applesauce to feed it to her. MA D stated she took Resident #1's blood pressure reading each time before she gave the medication but there was not a place on the MAR to document it as the nursing staff had not added it to the document to record it. MA D stated she always assessed Resident #1 before giving her medications, which included taking her blood pressure. MA D stated she normally wrote those readings down on paper and kept it during her shift in case anyone, such as the MD or the NP came to the facility, and wanted to know what they were for the resident. MA D stated, But at the end of the day, I usually destroy it, but when I am work, I write it in case I need to prove it (taken the resident's blood pressure). MA D stated taking the residents' blood pressure was important because if the blood pressure was too low and a medication was given when it was supposed to be held, the resident might go into crisis, like a seizure, or if the blood pressure was too high, then steps needed to be taken to lower it. An interview with the DON on 01/23/25 at 1:57 PM reflected that after state investigator intervention, the nursing management team went back and audited the resident's MAR and ensured all the MARs had corresponding vitals parameters (including blood pressure), if indicated, and in-serviced staff. The DON stated that even if the blood pressure was not on the MAR when it was generated, the medication aides as well as the nurses were capable of going in and revising the MAR and adding it . Record review of the facility's policy titled, Medication Administration Procedures dated 2003 reflected, .13. When ordered or indicated, include specific item(s) to monitor (e.g., blood pressure, pulse, blood sugar, weight), frequency (e.g., weekly, daily), timing (e.g., before or after administering the medication), and parameters for notifying the prescriber.