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	05/14/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents reviewed for care plans. The facility did not put a floor mat for Resident #1 as indicated in his care plan as an intervention in the resident's care plan who was a high fall risk while he was in his bed on 05/14/25. This failure can put residents at risk for falls to sustain injuries due to not following interventions for fall precautions in place. The findings included: Record review of Resident #1 admission record dated, 05/14/25, revealed a [AGE] year-old male readmitted to the facility on [DATE]. His diagnoses included Unspecified Parkinsonism (a progressive nervous system disorder, which affects the ability to move muscles and muscle spasms or jerks), involuntary abnormal movements, cognitive communication problem, need for assistance with personal care, and prostate cancer. Record review of Resident #1's quarterly MDS assessment, dated 02/08/25 revealed, Resident #1 rarely made himself understood, but he sometimes understood others. Resident #1 was dependent on staff for ADLs. Further the MDS revealed Resident #1 had a fall since admission and or reentry to the facility. MDS did not reflect BIMS. Record review of Resident #1's care plan revised on 04/13/24 revealed Resident #1 had a high fall risk related to unsteady gait and lack of awareness. The goal was for Resident #1 to be free from minor injuries until the next review date. The interventions included fall mat at bedside. Observation and interview with Resident #1 on 05/14/25 at 10:20 AM, revealed Resident #1 was in bed lying on his back, awake and attempting to climb out of bed. He had the call light within reach, his bed was in lowest position, and he was on a pressure relieving mattress with a pillow under both his knees. Resident #1 stated he was doing well. He said that he knew how to use the call light if he needed anything. Resident #1 did not have a floor mat next to his bed. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/14/25 at 10:34 AM , revealed ADON went to storage room and took a floor mat and took it to Resident #1's room and placed it on the floor next to Resident #1's bed. The ADON said the CNA may have removed Resident #1's floor mat to get cleaned because it was dirty with food. He said the overnight shift will usually remove the mats in the morning to avoid them being a tripping hazard for the residents. The ADON said the expectation was that when the resident was in bed and he was a fall risk, the interventions for fall, needed to be flowed. He said he was going to do an in-service making sure that fall precautions are in place. In an interview with CNA E on 05/14/25 at 10: 48AM, revealed she had put Resident #1 in bed when she noticed him falling asleep in the TV room. She said that she made sure that he had his call light, and his bed was in the lowest position. She said she did not see a floor mat in Resident #1's room this morning when she got Resident #1 up and when she put him in bed after breakfast. She said she was not aware that he required a floor mat because she hardly worked with Resident #1. She said the CNA that was familiar and usually worked with him had called in today. She said she should have asked his nurse if he required a floor mat. She said she checked on residents that are known to be fall risks frequently and kept their doors open so that any staff passing by can see them if they are trying to get out of bed without calling and assisting them . She said the floor mat as a fall intervention, would help to cushion Resident #1 if he fell out of bed. She said the risk to the resident was if he fell, he would hit the floor and hurt himself. In an interview with LVN F on 05/14/25 at 10:37 AM, she said she was Resident #1's nurse and CNA E was assigned to him today. She said she did not work on Monday; therefore, she does not know what happened to Resident #1's floor mat. She said the floor mat was a fall intervention required for Resident #1 and should be in place. She said floor mats can be a tripping hazard so the CNAs usually will remove them when helping the residents out of bed or when caring for them in bed. In an interview with DON on 05/14/25 at 2:09 PM, it was revealed Resident #1 had a lot of interventions for fall in place including being moved from the secure unit so that he could be closer to the nursing station for quick response and availability to staff. She said the floor mat was part of his fall precaution and the expectation was that when Resident was in bed, it should be on the floor next to his bed. She said it was possible someone moved it out of the way while providing care. In an interview with the ADM on 05/14/25 at 4:40 PM, she expected staff to provide interventions as needed, as scheduled, or as requested and to document what was provided. Record review of facility policy titled Preventive Strategies to Reduce Fall Risk revision date 10/05/16 reflected: Policy: The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Education: . Do not assume that individuals can figure out these things by themselves . Educate family members about safety measures and fall prevention. Provide instruction on how to identify risk and environmental hazards. Document education.

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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 interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 of 6 residents (Resident #10) reviewed for ADL care. The facility failed to ensure Resident #10 was provided showers as scheduled. This failure could place residents at risk of not receiving services and decreased quality of life. Findings included: Record review of Resident #10's admission record, dated 05/14/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side. Record review of Resident #10's quarterly MDS assessment, dated 04/29/2025, revealed a BIMS score of 14, indicating intact cognition. Further review of the MDS revealed Resident #10 required partial/moderate assistance in showering and substantial/maximal assistance in tub/shower transfer. Record review of Resident #10's care plan, dated 01/23/2025, revealed Resident #10 had an ADL self-care performance Deficit and required one staff assistance for bathing. Record review of Resident #10's ADL sheet for May 2025, revealed no response for 05/03/2025 and 05/10/2025, and there was no entry for 05/08/2025. Record review of Resident #10's nursing notes for May 2025 did not reveal Resident #10 refused any showers. Interview on 05/14/2025 at 2:43 pm, Resident #10 stated [staff] did not like giving her showers when it was time. Resident #10 stated the last time she had a shower was a week ago and she did not refuse. Interview on 05/14/2025 at 4:05 pm, ADON D stated Resident #10 had a shower on night shift yesterday morning, before her morning appointment. Surveyor requested shower sheet for 05/13/2025. ADON D stated she did not see one for 05/13/2025, but knew CNA C had given her one. ADON D stated CNA C was out sick right now. ADON D stated it was important to document showers because if the shower was not documented it was not done. She stated if showers were not given to residents there could be a risk of infection from not having clean skin. She stated nurses were supposed to monitor that residents received their showers and nurses were supposed to sign the shower sheets. She stated CNA's completed both paper shower sheets and documented showers in [EHR name]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/14/2025 at 4:16 pm, Resident #10 stated her shower days were Tuesdays, Thursdays and Saturdays in the morning. She stated she felt nasty and disrespected when she did not get her showers. She stated she cannot stand not bathing and it had her itching. She said they could even give her a bed bath. Interview on 05/14/2025 at 4:33 pm, the DON stated she expected staff to document if showers were given or refused. The DON stated the ADON was responsible to monitor showers were given. The DON stated there was no risk for missing one shower, and if Resident #10 had missed another day in a row, there could be a risk of infection. Interview on 05/14/2025 at 4:40 pm, the Administrator stated she expected staff to provide care as needed, as scheduled, or as requested and to document what was provided. Record review of facility policy titled, Bath, Tub/Shower, dated 2003, revealed the following: Goals 1. The resident will experience improved comfort and cleanliness by bathing. 2. The resident will maintain intact skin integrity. 3. The resident will be free from soil, odor, dryness, and pruritus following bathing. The policy revealed the procedure for bathing but did not reflect to document showers or refusals.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 4 (Emergency Response Cart 1) emergency crush carts reviewed for emergency preparedness. Facility failed to check inventory daily on an Emergency Response Cart 1 on C hallway from [DATE] to [DATE]. These failures could place residents at risk for delayed emergency response care. The findings included: Review of Emergency Response Cart 1's daily log inventory check off on [DATE] at 09:46 AM, revealed no check off was completed from [DATE] to [DATE] on Emergency Response Cart 1. Further review of the daily Emergency Response Cart 1 inventory log revealed it was also incomplete for [DATE] with the following items not checked off; Kling (a type of gauze bandage), blood pressure cuff, stethoscope, K-Y- jelly, and Backboard (this is a board required when doing CPR). In an interview with RN A on [DATE] at 09:50 AM, he was the charge nurse of the C hallway. He revealed the night 10 PM-6 AM shift were responsible for making sure that the emergency response carts were checked off nightly. He said each hallway had its own emergency response cart. RN A was observed investigating the emergency response cart and he stated all items were available on Emergency Response Cart 1. He said he did not know why Emergency Response cart 1 was not checked off nightly. He said that it was important to make sure that the inventory log had been signed and each item checked off to make sure emergency response items were on the cart. He said the risk of not checking the emergency response cart was they would not know if items needed for an emergency were missing. In an interview with LVN B on [DATE] at 4:09 PM, she said she usually checked off the emergency response carts whenever she worked the night shift 10PM-6AM. She said each hallway had its own emergency response cart and the nurses on that hallway were responsible to checking off their emergency response carts. LVN B said she made sure that the emergency response carts in her hallway [B hallway] were always checked off nightly and she expected the other nurses on the other hallways to do so. She said the risk of not checking the emergency response carts were items required to respond in an emergency would be missing. In an interview with ADON on [DATE] at 10:37AM, he said the night shift nurses were responsible for emergency response carts checking off crash carts nightly. He said the charge nurses were supposed to monitor that it was done. He said the expectation was that all emergency response carts were working and accounted for to make sure all items were on the emergency response cart in case of an emergency. ADON said all nurses were responsible for making sure that the emergency response carts had all items needed. He said it was important to check the emergency response cart daily so that you it would not place a resident at risk in case of an emergency in the facility by delaying care. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on [DATE] at 2:09 PM, she stated the expectations were the nurses maintained the emergency response cart and it would be ready when they have a code and that the carts were being monitored by the charge nurses. She stated she would in-service and make sure the emergency response carts inventory logs were checked off and up to date and ready in case of a code blue episode so that there was no delayed care for a risk during a code. In an interview with ADM on [DATE] at 4:40 PM, she said the expectation for staff were to complete checks of emergency response carts and document that it was being done. She said it was important to be checked daily because at any moment the emergency response carts could be needed when responding to a code blue, therefore, making sure everything was on the emergency response carts was important. Record review of facility Central Supply Reference Guide dated 10/1023 reflected ALL Closets, all shelves, all bins, as well as the crash cart will be checked for expired items. The facility did not have a policy for Cardiopulmonary Resuscitation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents in 1 of 5 rooms observed. The metal vent cover was missing from the air conditioning opening in the ceiling. The built-in dresser was missing 4 dresser drawers and 2 dresser doors. This facility failure could place Residents at risk for an unsafe environment. Findings include: Record review of Resident #2's face sheet dated 05/14/2025 revealed a [AGE] year-old admitted [DATE] with a readmission on [DATE]. Admitting diagnosis of Acute and Chronic Respiratory Failure with Hypercapnia (the inability to adequately remove carbon dioxide from the blood, leading to elevating levels of CO2 in the blood (hypercapnia) ; Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (sudden worsening in airway function and respiratory symptoms in patients with COPD (a group of lung diseases that block airflow and make it difficult to breathe) ; Essential (Primary) Hypertension (high blood pressure where the underlying cause is unknown). Record review of Resident #2's discharge assessment - return anticipated MDS dated [DATE] reveals BIMS score noted to be 15/15 with memory intact. Resident #2 needs partial to substantial/max assistance with ADL care. Resident #2 has shortness of breath or trouble breathing with exertion, sitting at rest, and when lying flat. Record review of Resident #2 physician orders reveals continuous oxygen 2-4 lpm via nasal cannula or cylinder to keep O2 levels at or great that 93% every shift r/t Acute and Chronic Respiratory Failure with Hypercapnia (the inability to adequately remove carbon dioxide from the blood, leading to elevating levels of CO2 in the blood (hypercapnia). Record review of Resident #2's care plan revealed resident will have no s/sx of poor oxygen absorption through the target date. (06/23/2025) Interventions are to give medications, monitor side-effects and effectiveness, deliver oxygen through nasal cannula during meals, monitor s/sx of respiratory distress and report to MD PRN. In an interview on 05/14/2025 at 11:55 am with Resident #2's revealed that her room is too hot. Resident #2 revealed that she has a hard time sleeping and breathing at night. Observed resident was using oxygen while up in her wheelchair. Resident states she must use her oxygen 24 hours a day. Observation on 05/14/2025 at 12:10 pm in room [ROOM NUMBER] revealed the metal vent cover was missing from the air conditioning opening in the ceiling. Observed a large amount of black substance up in the ceiling area of the opening attached to the metal tubing. Warm air was blowing out of the opening. The room was warm with no air circulating. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observed the built-in dresser with 4 missing dresser drawers and 2 dresser doors. Resident #2's personal clothes were thrown in the dresser at the bottom. The metal brackets were exposed that could be hazardous to Resident #2 and causing injury. In an interview on 05/14/2025 at 3:06 pm with maintenance assistant revealed he has been at the facility just over a month. He hasn't worked in long term care before. What about the thermometer he was holding and what he was doing? Maintenance assistant revealed he was checking room temperatures. He started checking at 12:45 pm. Why was he checking the temperatures. He revealed it because it was the hottest day of the year so far. Have any residents complained of being too hot? Has resident in room [ROOM NUMBER] complained of being too hot? After checking room [ROOM NUMBER], the maintenance assistant revealed her room temp is 74. He is checking temps every 30 minutes. Maintenance assisted stated the maintenance director was on vacation. Proceeded to Hall 3 of the building with maintenance assistant. At 3:13 pm in room [ROOM NUMBER], the maintenance assistant said the average was 73.8. He proceeded to point the thermometer at all walls in the room. Why was the ceiling tile and metal vent cover removed? Said it just fell off. Temped the vent by window, read 67. Vent with ceiling cover removed was 74.7. Stated assumed it was the return air vent. Does it feel warm here? The maintenance assistant stated that he sweats a lot, not like a normal person. Today at 2:15 pm it was fine. Shown picture with ceiling piece missing. Said he wasn't looking, I didn't notice. Just more focused on taking the temps. Do you know why it's off? He revealed, no idea. Does it affect the air? It should, because the warm air is coming down, having it uncovered makes it a little warmer, it's allowing the warm air to come through. Went to the following rooms with temps: 334 - 72 average. 330 - 74 average. Is this the average temp in the room? Yes. Who is responsible for responding to complaints of hot or cold room temps? Normally ask the Maintenance Director. What is the risk? I'm assuming there is always a risk, sweating, passing out. Overheated? Yes. On days like today, why is it important to make sure AC working? Make sure the residents are comfortable, not too hot, so they won't pass out, sweat excessively and be comfortable. Do you know what the temp is supposed to be? 74-78 is supposed to be okay. This section (300 hall)? It's a different unit, it was built in phases. Way back then they used a different system, so not 100% sure what exactly sure what system controls what. In an interview on 05/14/2025 at 5:30 pm the ADM revealed that she was not aware of the vent cover missing in room [ROOM NUMBER]. Revealed the black substance observed up inside the vent. Revealed to ADM that Resident #2 complained of her (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room being too hot causing problems with sleeping and difficulty breathing. Do you know there are 4 drawers and 2 doors missing from the built-in dresser? The ADM revealed that she was aware of this, and the dresser is old and was not able to be repaired before Resident #2 moved into that room from another room. Maintenance will work on these repairs. Record review of facility's policy on Self-Reporting Protocols - Air Conditioning Failures if Outdoor Temperature is or will be 90 Degrees or Above revealed in part, Do the following: Identify the source of the issue (air handler, electricity, fire system relays, etc); Utilize the Extreme Heat Procedure from the Emergency Prepares Binder .