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| 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 07/08/2025 |
| NAME OF PROVIDER OR SUPPLIER Five Points at Lake Highlands Nursing and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| 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. (continued on next page) |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to residents who are unable to carry out activities of daily living for one (Resident #1) of four residents reviewed for quality of life. The facility failed to assist Resident #2 with timely incontinence care . These failures could put residents at risk of poor personal hygiene, impaired skin integrity, and decreased feelings of self-worth and dignity. Findings included: A record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had history and diagnoses of Hemiplegia (complete paralysis of one side of the body) and Hemiparesis (involves weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side; Need for Assistance with Personal Care; Anxiety and MDD (a mood disorder that causes a persistent feeling of sadness and loss of interest); Obesity Class 2 (a Body Mass Index [BMI] of 35 to 39.9, a calculated measure of weight relative to height and is associated with increased health risks); and Family history of Human Immunodeficiency Virus [HIV] Disease. A BIMS score of 14 suggested Resident #2 was cognitively intact. Resident #2 had no behavioral symptoms or rejection of care behavior during the MDS review period. Resident #2 required assistance with ADLs and was always incontinent of bladder and bowel. Resident #2 was at risk for pressure ulcers/injuries. Record review of Resident #2's comprehensive care plan, printed 06/08/25, reflected the following: [Resident #2] has potential impairment to skin integrity and or potential for pressure injury r/t morbidly obese, need assistance, DM 2 (a chronic condition characterized by insulin resistance and high blood sugar levels), Hemiplegia, bowel, and bladder incontinence (Date Initiated: 01/21/25). Interventions included .assistance, supervision, reminding for ADL; Keep skin clean and dry; and needs pressure reducing mattress, pillows, to protect the skin while up in bed. [Resident #2] has bowel incontinence (Date Initiated: 01/23/25). Interventions included Apply barrier cream after every incontinent episode; Check resident every two hours and assist with toileting as needed; Provide peri care after each incontinent episode; and See care plans on Mobility, ADLs, Cognitive Deficit, Communication. [Resident #2] has an ADL Self Care Performance Deficit (Date Initiated: 01/21/25). Interventions included Bed mobility: requires staff x1 for assistance; Toilet use: requires staff x1 (one person) for assistance; Encourage the resident to use bell (press call button) to call for assistance. [Resident #2] has bladder incontinence (Date Initiated: 01/23/25). Interventions included INCONTINENT care at least Q2H (every two hours) and apply moisture barrier after each episode; and Monitor/document for s/sx (signs and symptoms) UTI. [Resident #2] has behavior problem r/t false accusation, refusal of care, and refusal of medications (Date Initiated: 04/15/25; Revision on: 06/08/25 by DON). Interventions included Anticipate and meet [Resident #2's] needs; Assist the resident to develop more appropriate methods of coping and interaction; Encourage the resident to express feelings appropriately; Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations; Document behavior and potential causes; and praise any indication of [Resident #2's], progress/improvement in behavior. [Resident #2] is risk for falls (Date Initiated: 01/23/25). Interventions included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; and Staff x 2 (two persons) to assist with transfers. [Resident #2] has a pressure ulcer or potential for pressure ulcer development (Date Initiated: 01/23/25). Interventions included Incontinent care after each episode and apply moisture barrier; and Use lifting device, draw sheet, etc., to reduce friction. Review of Resident #2's digital Visual/Bedside Kardex Report, printed on 06/08/25, reflected Safety, Skin Integrity, Bathing, Eating/Nutrition, Toileting, Transferring, Personal Hygiene/Oral Care, Dressing, Mobility, Bladder/Bowel care needs. Resident #2's Bladder/Bowel needs required incontinent care at least Q2H and apply moisture barrier after each episode. Resident #2's Toileting needs reflected Apply barrier cream after every incontinent episode; Check resident every two hours and assist with toileting as needed; Incontinent care after each episode and apply moisture barrier; and Provide peri-care after each incontinent episode. Resident #2's Mobility needs reflected Bed Mobility: requires staff x1 (one person) for assistance; [Resident #2] used a wheelchair. Resident #2's Transferring needs reflected Staff x 2 (two persons) to assist with transfers. During an observation and interview on 06/08/25 at 4:10 PM revealed Resident #2 lying flat on her back in bed. Resident #2's head rested on one pillow, a sheet and blanket covered her up to her chest. LVN I informed Resident #2 that she would perform a head-to-toe skin assessment. Resident #2 acknowledged understanding and agreed. When</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records review the facility failed to ensure each resident received adequate supervision and transferred in a safe manner to prevent an accident for one (Resident #1) of four residents reviewed for accidents and hazards, in that: The facility failed to provide Resident #1 with adequate supervision and assistance with transfers to prevent an accident. On 05/14/25, Resident #1 had an unexpected or unintentional incident, which resulted in an injury to her left knee when transferred by two CNAs from the bed to a dialysis chair. On 05/19/25, the facility sent Resident #1 to the hospital after an x-ray of the bilateral (both) knees, dated 05/16/25, revealed a possible acute nondisplaced fracture (the bone did not move when the fracture occurred). follow-up x-rays or CT scan is recommended. On 05/19/25, Resident #1 had surgery to her left distal femur (lower part of thighbone, located just above the knee joint) to repair the fracture. An IJ was identified on 06/20/2025 at 1:30PM. The IJ template was provided to the facility on at 1:30 PM. While the IJ was removed on 06/20/2025 at 9:45PM, the facility remained out of compliance at a scope of Isolated and severity level of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure placed residents at considerable risk of significant injury, harm, and/or impairment. Findings included: Record review of Resident #1's 5-day MDS Assessment, dated 05/29/25 reflected an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had an admission history and diagnoses of CHF ([congestive heart failure] a chronic condition where the heart is unable to pump blood effectively, leading to a buildup of fluid in the lungs and legs); seizure disorder; CKD dependent on dialysis; and age-related physical debility. A BIMS score of 11 suggested Resident #1 had a moderate cognitive decline. Resident #1 had no behavioral symptoms or rejection of care behavior during the MDS review period. Resident #1 was dependent of staff assistance with ADLs and was frequently incontinent of bladder and always incontinent of bowel. Resident #1 was at risk for pressure ulcers/injuries. Record review of Resident #1s comprehensive care plan, printed 06/09/25, reflected the following: [Resident #1] has surgical site to the left knee and left thigh (Date Initiated: 05/23/25). Interventions included Observe for s/s of infection and Observe for s/s of pain during treatment and medicate PRN per physician's orders. [Resident #1] has an ADL Self Care Performance Deficit (Date Initiated: 03/31/25). Interventions included Bed mobility: requires staff x1 for assistance; Encourage the resident to use bell to call for assistance; and Transfer: require a Mechanical Lift as a Mechanical Aid and 2 staff members to assist in transfers (Date Initiated: 05/20/25 by DON); [Resident #1] has a history of making false accusations/fabrications on staff, refusal of care, and refusal of medications (Date Initiated: 03/31/25; Revision on: 05/27/25). Interventions included Educate [Resident #1/RP/CG] of causative factors and measures to prevent false accusations; and Monitor/document/report and Psych Services to eval and treat as needed. Record review of Resident #1's active physician orders reflected:- Order date 03/28/25: Acetaminophen Oral Tablet 325 mg. Give 2 tablets by mouth three times a day for Pain. Give 2 tablets to equal 650 mg, not to exceed 3000 mg a day. [Discontinued 05/19/25] - Order date 03/28/25: Resident to have pain consult with pain management NP to assess for pain medication needs and /or modifications. [Discontinued 05/19/25] - Order date 03/28/25: DIALYSIS DAYS MONDAY-WED-FRI [Discontinued 05/19/25] - Order date 03/28/25: NO BP/BLOOD DRAW OR FINGER STICK TO RIGHT ARM [Discontinued 05/19/25] - Order date 03/31/25: Anticoagulant Monitoring: monitor for signs and symptoms of adverse reaction: . rash . tissue necrosis . hemorrhage . purple toe syndrome, Increased fracture risk with long term use. Every shift. [Discontinued 05/19/25] - Order date 05/16/25: Xray of left Femur 2V (two views), Bilateral (both sides) Hip 2V, and Left Tibia & Fibula (the bones that make up the lower leg) 2V. - Order date 05/15/25: Tylenol Extra Strength Oral Tablet 500 mg. Give 2 tablets orally every 8 hours as needed for Pain. Two tablets to equal 1000 mg. - Order date 05/22/25: Norco tablet 5-325 mg. Give 1 tablet by mouth every 6 hours as needed for Pain. - Order date 05/23/25: Cleanse left knee surgical site with wound cleanser, pat dry apply Betadine then cover with protective dressing change every Tuesday - Thursday and as needed. Every day shift every Tuesday, Thursday for wound care. - Order date 05/23/25: Cleanse left thigh surgical site with wound cleanser, pat dry apply Betadine then cover with protective dressing change every Tuesday - Thursday and as needed. Every day shift every Tuesday, Thursday for wound care. - Order date 05/23/25: PT to eval and treat. - Order date 05/23/25: PT to eval and treat as indicated. PT Clarification: Patient to receive skilled PT services 3x/week for 60 days. - Order date 05/27/25: [Provider Name] may provide</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on record review, observations and interviews, the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents, for one (medication cart #1) of two medication carts observed for medication storage. On 06/09/25 at 7:53 AM, MT Q failed to ensure medications were secured or attended to by authorized staff when MT Q did not lock the medication cart (#1) before she walked away. This failure placed residents at risk of a potential for more than minimal harm if a resident accessed and ingested medications or drug diversion. Findings included: During an observation on 06/09/25 at 7:53 AM revealed a medication cart (#1) unlocked, unattended and not under direct observation of authorized staff. The lock was in the out position, and anyone could open the drawers and left the medications accessible. Various multi-dose bottles of OTC medications were organized in the top drawer of the medication cart. Residents' routine and PRN medications and medication blister packs were organized in other drawers of the medication cart. One resident was ambulating back and forth in the hallway during observation. At 7:55 AM, the Investigator observed MT Q walking towards the medication cart from approximately twenty-five feet away. During an interview on 06/09/25 at 7:56 AM, MT Q said she did not normally leave the medication cart (#1) unlocked when she walked away. MT Q stated she was only right there and pointed at a resident room down the hall, it was her fault, and she knew that leaving the medication cart unlocked and walking away should never happen. MT Q said she received training during new hire orientation. MT Q stated a resident could get a hold of medications and have an allergic reaction. During an interview on 06/09/25 at 12:31 PM, the DON who said that it was not acceptable to leave medication carts unlocked and unattended or not within direct line of site and arms reach for resident safety and to prevent drug diversion. The DON said if residents could access the medications, swallow a medication that they are allergic to, could have an adverse reaction. The DON said she would conduct an in-service about medication storage and safety. The DON stated surveillance of medication carts being locked were conducted regularly for quality assurance. Review of the facility's policy Medication Storage - Storage of Medication, dated 05/16, reflected:- In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access to medication carts. medication supplies should remain locked when not in use or attended by persons with authorized access.</p> | | |