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	11/06/2025

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 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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 resident (Resident #3) of 6 residents reviewed for ADLs. The facility failed to ensure Resident #3 had his fingernails cleaned and trimmed on 11/06/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Record review of Resident #3's admission MDS assessment dated [DATE] reflected Resident #3 was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dehydration (occurs when the body loses more fluids than it takes in, leading to a depletion of water and electrolytes), coronary artery disease (a condition where the arteries that supply blood to the heart [coronary arteries] become narrowed or blocked), and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland, a walnut-sized organ located below the bladder in men). Resident #3's had a BIMS score of 05 out of 15, which indicated severe cognitive impairment. The MDS assessment indicated Resident #3 required maximum assistance with personal hygiene. Record review of Resident #3's Care Plan dated 10/01/25, reflected the following: Focus: [Resident #3] has an ADL selfcare performance deficit. Goal: [Resident#3] will maintain current level of function . Personal hygiene. Interventions: Assist with personal hygiene as required . BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.Record review of Resident #3's Shower sheets on 11/06/2025 revealed Resident #3's last bed bath was on 11/04/2025, and shower was on 10/30/2025.An observation and interview on 11/06/25 at 09:01 AM revealed Resident #3 was lying in his bed. Resident #3's nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers. The nails were discolored tan with brown matter underneath. Resident #3 stated he would like his fingernails trimmed and cleaned. In an interview on 10/06/25 at 10:27 AM, CNA B looked at Resident #3's fingernails and stated she would clean and trim them today after Resident #3's shower. CNA B stated that both CNAs and Nurses were responsible for nailcare. She said that if the resident has diabetes, then nurses trimmed their fingernails. She stated that if nails were long and dirty, residents may be at risk of infection. In an interview and observation on 11/06/25 at 10:33 AM, LVN C stated that both nurses and CNAs were responsible for doing nail care for the residents. He stated that fingernails should be trimmed and cleaned on shower days and as needed. He stated that Resident #3 had dirty, untrimmed nails, and will provide nail care to the Resident today. He stated that dirty nails could lead to a risk in infections. In an interview on 11/06/25 at 2:47 PM, the ADON stated nail care should be completed as needed and every time aides washed the residents' hands. The ADON stated nails should be observed daily. The ADON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The ADON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The ADON stated she would do the routine rounds to monitor. The ADON stated residents having long and dirty nails could be an infection control issue. Record review of the facility's policy titled, Nursing Policy & Procedure Manual-Nail Care undated reflected, Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails . It includes cleansing, trimming, smoothing, and cuticles are and is usually done during the bath.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to 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 2 of 6 residents (Resident #1, Resident #2) observed for infection control. The facility failed to ensure CMA A disinfected the blood pressure cuff in between blood pressure checks for Residents #1 and Resident #2 during a medication pass on 11/06/25. These failures could place residents at-risk of cross contamination which could result in infections or illness.Observations on 11/06/25 between 09:24 AM and 07:43AM revealed CMA A took a blood pressure cuff from the top of the medication cart, entered Resident #1's room, checked his blood pressure and put the blood pressure cuff back on the top of the medication carts without sanitizing it. CMA A gave Resident #1 his morning medications. CMA A moved the medication cart to the front of Resident #2's room. CMA A retrieved the blood pressure cuff from the top of the medication cart and checked Resident #2's blood pressure. CMA A returned to the medication cart and placed the blood pressure cuff on top of the medication cart, and again did not sanitize the cuff. CMA A gave Resident #2 her morning medications. In an interview with CMA A on 11/06/25 at 09:44 AM, she stated she cleaned the blood pressure cuff at the start of her shift this morning. She stated she cleaned the blood pressure cuff twice during her shift and added that she sanitized the blood pressure cuff between two residents' use. CMA A stated the risk of not cleaning the cuff between each resident was cross-contamination, spread of germs, and it could harm residents who were immunocompromised [low immune system]. In an interview with the Regional Nurse on 11/06/25 at 1:25 PM, he stated the staff were trained to disinfect the reusable equipment between residents' use. He stated the risk to the resident was the development of infection.In an interview with the ADON on 11/06/25 at 2:47 PM, she stated all staff were expected to follow infection control policy when in the building. She stated all equipment should be cleaned between patient-use according to the infection control policy. She stated there was an infection control policy specifically for equipment. The ADON stated the risk to the residents was cross contamination. Record review of the facility's policy titled Infection Control Policy & Procedure Manual 2019 UPDATED March 2023 reflected 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.6. Resident care equipment and articles. 3. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. Equipment that is visibly soiled with blood or body fluids will be cleaned immediately with approved disinfectant by the nursing assistant.