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	12/11/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
	455895	A. Building B. Wing	12/11/2025

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 0580 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 observation, interview and record review, the facility failed to immediately notify the resident representative and the resident's physician, when there was significant change in resident's physical, mental, or psychosocial status for one of eight (Resident #2) reviewed for resident rights. The facility failed to ensure LVN K notified the RP and the physician when Residents #2 was hit with the door. On 11/24/25 LVN K entered Resident #2's room hitting him with the door, she failed to complete an incident report, document assessments completed, and any required ongoing monitoring for delay in injury and failed to notify the resident's responsible representative of the resident's broken dentures. This failure could place residents at risk of not having their responsible party, physician and oncoming staff notified of changes, which could result in a delay in medical intervention and a decline in health. Findings included: Record review of Resident #2's Face Sheet dated 12/12/25 reflected an [AGE] year-old female with an admission date of 11/22/25. Her diagnoses included Alzheimer's disease. Record review of Resident #2's admission Nurses notes dated 11/22/25 and completed by LVN K, reflected the resident was ambulatory without assistive device, required minimal assistance with dressing, was able to toilet herself, required a secured unit, was alert to person but had short term memory impairments and difficulty in decision making when faced with new tasks or situations and had wandering behaviors. Resident was on anticoagulant (blood thinner) medication. Review of Resident #2's base line care plan initiated on 11/23/25 reflected that the resident was at risk of falls with interventions that included, anticipate and meet the resident's needs, call light within reach and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Record review of Resident #2's Physician order summary report dated 12/10/25 reflected, . Admit to secure unit with active exit seeking behavior. with a start date of 11/23/25. Record review of Resident #2's Nurse Progress note dated 11/24/25 at 14:30 (02:30 p.m.) by LVN K, reflected Resident continues to frequently remove her upper dentures and wrap them in paper towels. This nurse has re-educated the resident on the importance of keeping dentures in a safe and designated container. Resident acknowledges understanding but continues the behavior. This nurse is concerned that the dentures may become misplaced or accidentally discarded. Denture cup placed at bedside and reinforced use. Will continue to monitor and reinforce education Record review of Resident #2's Nurse Progress note dated 11/26/25 by LNV K reflected, Effective date 22:24 (10:24 p.m.) Late Entry. This nurse was making rounds and when opening the residents room door she was standing behind it and the door bumped the resident. In an interview on 12/09/25 at 3:00 p.m. with resident #2's Representative they stated the resident was receiving hospice services at home and a brief respite request had been made to provide a break for Resident #2's familymember. They stated Hospice Agency J arranged with the facility for the resident to be admitted on [DATE] for a five day stay. The Representatives stated when they picked Resident #2 up on 11/26/25 they noticed bruises on both of the resident's arms and on the left side of her forehead above her left eye and her dentures were broken. Both stated they asked the facility about the bruises and were told the bruise on her right arm was from a blood draw and then they were told about the incident with the nurse hitting the resident with the door. They stated they were told no one knew about the broken dentures. Both stated they were never notified about the resident receiving lab work or about the incident with the door or her broken dentures and felt they should have been contacted. In an interview with LVN K on 12/09/25 at 03:45 p.m., she normally worked double weekends and was on duty the weekend of 11/22/25 and did the admission on Resident #2. She stated the resident would wander throughout the unit and had wandered into a few other residents' room. She stated she was making round on 11/24/25 around 10:00 p.m. and knocked on Resident #2's door and then opened it. She stated the resident was standing behind the door and when she opened the door and contacted the resident. She stated the resident said ouch but stated she did not fall. She stated she assessed the resident and did not notice any bruises, cuts or injury and the resident denied any pain. She stated she should have documented the incident and put on the report but stated she just failed to do so. She stated she was going to tell the family when they came in the next day but stated she did not see them. She stated she had also noticed Resident #2 was taking her upper denture in and out and had wrapped it up in a napkin one day. She stated they placed the denture in a cup and would put them back in for her to eat but had not noticed they were broken. She stated the day the Speech Therapist came to evaluate her on 11/24/25 the Speech Therapist had brought the dentures to her and told her they were broken. She stated she placed the dentures in a cup and locked them in the

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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 1 of 7 residents (Resident #3). The facility failed to ensure Resident #3's room was free from hazards. This deficient practice could place residents at risk of living in an unsafe environment which could lead to falls and injuries.Findings include: Record review of Resident #3's Face Sheet, dated 12/09/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and difficulty walking. Record review of Resident #3's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 15, an intact cognitive response. For ADL care, it reflected the resident required substantial assistance. Record review of Resident #3's Comprehensive Care Plan, dated 12/09/2025, reflected the resident was a risk for falls. In an observation on 12/09/25 at 11:40 AM, Resident #3 had a large extension cord running across the floor from her television on the wall to the outlet next to the side of her bed. The television did have an outlet on the same wall. Resident #3 had another extension cord connected to two fans located next to a wall in the room. The bed adjuster sitting on top of the resident's bed had exposed wires. In an interview and observation on 12/09/25 at 1:00 PM, the Maintenance Supervisor observed the extension cords connected in Resident #3's room and stated she should not have the extension cords because the resident could trip and fall from them. He stated he did not know who placed the extension cords in the resident's room. He stated the resident should have had American Power Conversion cords to connect the devices, instead of the extension cords. He stated he was going to get the APC cords for the resident's room. He also observed the exposed wires for the bed adjuster and stated it was a low shock but should not be exposed. In an interview on 12/10/25 at 9:42 AM, the Administrator was advised of Resident #1's room having the extension cords and exposed wires in the room. He stated he was not aware of this. He stated it was a team effort, and everyone should be paying attention to this, including maintenance. He stated the main risk to the resident was a fire could start and the resident could fall. Record review of the facility's policy on Resident Rights, undated, revealed 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. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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	12/11/2025

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)

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	12/11/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #5) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #5 received any of her scheduled showers based on records reviewed for November and December 2025. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem.Findings Included: Record review of Resident #5's Face Sheet, dated 12/09/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Cerebral Infarction impacting left dominant side (stroke) and reduced mobility. Record review of Resident #5's Quarterly MDS assessment, dated 9/16/25, reflected a BIMS score of 14, an intact cognitive response. For ADL care, it reflected the resident required total assistance. Record review of Resident #5's Comprehensive Care Plan, dated 12/02/2025, reflected the resident was at risk for impairment of skin integrity and an intervention included keeping her skin clean and dry. In an interview on 12/09/25 at 12:05 PM, Resident #5 stated she did not receive her three scheduled showers a week and would be lucky if she got a bed bath. She stated she had not had a shower in over 5 weeks, prior to the shower she had received on 12/08/25. She stated she had to complain to leadership about not getting a shower and she was able to get one on 12/08/25. She stated she wanted her showers but was told by staff they did not have time. She stated the CNAs also told her the shower bed was broken. Record review of Resident #5's shower sheets for the month of November and December 2025 reflected the following:11/03/25: No indication of whether a bed bath or shower was provided.11/07/25: Refused11/19/25: Bed Bath12/04/25: Bed Bath12/05/25: Bed Bath12/08/25: Shower In an interview on 12/09/25 at 2:00 PM, LVN B was advised of Resident #5, only having shower/bath sheets for the dates previously stated. She stated CNAs rotated to different halls daily and the resident hall did not have a dedicated CNA. She stated the CNAs scheduled to work the A-hall, should check the shower schedule to see what residents were scheduled for showers for that day. She stated CNAs were supposed to turn in shower sheets at the end of their shift and the nurse assigned to the hall should check with the resident to confirm they had received their shower, and if they had refused, they were to attempt to persuade the resident to take one and contact the RP if they still refused. She stated if the resident did not receive their scheduled showers, they could have skin break down and stink. In an interview on 12/10/25 at 9:03 AM, LVN C stated he covered the hall of Resident #5. He stated the resident should receive a shower or bed bath at least three times a week. He stated sometimes the resident may refuse. He stated the resident should still have a shower sheet stating the resident refused and he attempts to talk them into getting a shower. He was advised of Resident #5 not receiving her scheduled showers and he stated the resident should receive her showers from the 3:00 PM to 11:00 PM shift. He stated he did not review the shower sheets to ensure the resident was not getting showers. He stated this was the ADON's responsibility. He stated the risk of the resident not receiving showers could result in skin breakdown and infections. In an interview on 12/10/25 at 9:48 AM, ADON E stated she managed the hall of Resident #5. She stated the resident should receive showers three times a week. She was advised of the shower sheets reviewed for November and December 2025, and the dates indicated a shower or bed bad was given. She stated the CNAs checked the shower scheduled to see who should receive the shower that day. The Nurses should check the shower sheets to ensure the resident was provided their shower. She stated she checked the shower sheet book weekly to see if showers were being given and she collected all of the shower sheets monthly. She stated she had not collected November's shower sheet yet to see if residents were getting her shower, so she was not aware of this. She stated the resident had not mentioned to her that she was not getting her showers. She stated the risk of residents not getting their shower was they could get sick, get an infection, and develop wounds. She stated all CNAs completed showers, and it was based on whoever CNA was assigned to the Hall during their shower schedule. Record review of the facility's policy on Bath, Tub/Shower, undated, revealed Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. The resident will receive assistance with bathing according to their resident centered plan of care.

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	12/11/2025

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

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	12/11/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure adequate supervision and put measures in place to prevent Resident #1 who was at risk for eloping from the facility. On 09/29/25, Resident #1 eloped out of the facility and was found in a nearby hospital about 12 hours later. Resident #1 retuned back to the facility and continued on one-to-one supervision. The noncompliance was identified as Past Non-compliance (PNC). The Immediate jeopardy (IJ) began on 09/29/25 and ended on 09/30/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of potential accidents, injuries, harm, or death.Findings include: Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male with an initial admission date of 8/18/2025. Resident #1 had a BIMS of 5 indicating he was severely cognitively impaired. He required partial assistance with walking and ADLs. His pertinent diagnoses included non-Alzheimer's dementia (forms of cognitive decline not caused by Alzheimer's disease), anxiety, hypertensive heart disease (refers to heart problems from long-term high blood pressure), osteoarthritis (a degenerative joint disease especially in hands, hips, knees, and spine), and psychotic disorder (a mental health condition causing a break from reality, characterized by symptoms like hallucinations and delusions, accompanied by disorganized thinking, speech, and behavior), Intervertebral disc degeneration (breakdown of discs that separate the bones of the spine). Resident #1's height was 72 inches and weight was 283 pounds. Record review of Resident #1's comprehensive care plan with revised date of 8/20/25 reflected, Focus: [Resident #1] is at risk for elopement as evidenced by: Lack of safety awareness and cognition impairment. Goal: [Resident #1] Will remain safe within facility unless accompanied by staff or other authorized person through review date. Intervention: [Resident #1] Assess/record/report to MD risk factors for potential elopement such as: Wandering, Repeated requests to leave facility, statements such as I am leaving I am going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital will not leave facility unattended through the review date. Distract [Resident #1] from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books . Record review of Resident #1's comprehensive care plan with initiation date of 09/29/25 and revised date of 10/28/25 reflected, Focus: Actual elopement: [Resident #1] left the facility unattended. Goal: To find [Resident #1] without harm and return him to the facility. Intervention: [Resident #1] Will remain safe in the facility, with no further elopements or elopement attempts, unless accompanied by staff or other authorized person through review date.Assess/record/report to MD risk factors for potential elopement such as: [Resident #1's] elopement or attempted elopement, Wandering, Repeated requests to leave facility, statements such as I am leaving I am going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital. Staff to provide 1 on 1 Supervision, until discharge from facility. Record review of Resident #1's initial elopement risk assessment dated [DATE] reflected, [Resident #1] was placed on secured unit. [Resident #1] exhibits wandering behavior and is frequently exit-seeking. Resident identified as high risk for elopement. Safety measures in place and staff will continue close monitoring . Record review of Resident #1's progress notes by RN A dated 09/29/25 at 7:20 AM reflected At 11PM shift rounds, [Resident #1] was in his room. [At] 12.58 AM, [Resident #1] sat at the TV room. Rounds and checks were done. [At] 04:37 AM, [Resident #1] refused blood draw. At 06:30 AM, nurse saw [Resident #1] sitting in the TV room, Nurse went to administer medication to a resident, and on coming back, [Resident #1] was not on his seat. Rooms were searched. Code orange ([NAME]) was called MD, ADON, Administrator notified. At 0655 AM, [Resident #1's] responsible party was notified that resident left the building without letting anyone know. Police were notified. Record review of Resident #1's progress notes by the Administrator dated 9/29/25 at 8:49 PM reflected, Notified Responsible Party that [Resident #1] is in the hospital and being evaluated. Medical director (MD) and Nurse Practitioner (NP) notified. Record review of Resident #1's progress notes by LVN K dated 9/30/25 at 1:47 AM reflected, [Resident#1] returned to the facility from the hospital in stable condition via ambulance. Upon arrival, resident was alert and oriented to baseline. Vital signs were obtained and remained within normal limits . No signs or symptoms of distress, discomfort, or pain noted. Resident was assisted to his/her room safely by the Emergency Medical

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	12/11/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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	12/11/2025

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 0849 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 interview and record review the facility failed to obtain from hospice the hospice election form, hospice plan care, and physician certification and recertification of the terminal illness specific to the patient and failed to designate a member of the facility's interdisciplinary team who was responsible for working with hospice representatives to coordinate care to the resident for one of three (Resident #2) residents reviewed for hospice services. The facility failed to coordinate care between the facility and Hospice Agency J for Resident #2 at the time of her Respite stay from 11/22/25 through 11/26/25 which resulted in her not receiving her Hospice aide services from 11/24/25 through 11/26/25. These failures could place residents on hospice at risk of not having services coordinated between service providers.Findings included:Record review of Resident #2's Face Sheet dated 12/12/25 reflected an [AGE] year-old female with an admission date of 11/22/25. Her diagnoses included Alzheimer's disease. Record review of Resident #2's Hospice Agency J Face sheet/staff assignments dated 10/17/25 reflected, Hospice Aide 5 visits weekly, Record review of Resident #2's admission Nurses notes dated 11/22/25 and completed by LVN K, reflected the resident was ambulatory without assistive device, required minimal assistance with dressing, was able to toilet herself, required a secured unit, was alert to person but had short term memory impairments and difficulty in decision making when faced with new tasks or situations and had wandering behaviors. Resident was on anticoagulant (blood thinner) medication. Review of Resident #2's base line care plan initiated on 11/23/25 reflected, [Resident #2] has a terminal prognosis and/or is receiving hospice services.Interventions. work cooperatively with hospice team to ensure the resident's. physical and social needs are met. Record review of Resident #2's Physician order Summary dated 12/10/25 reflected, .Resident receives care from Hospice Agency J. with a start date of 11/24/25. In an interview on 12/09/25 at 3:00 p.m. with Resident #2's Representative they stated the resident was receiving hospice services at home and a brief respite request had been made to provide a break for Resident #2's Family member. They stated Hospice Agency J arranged with the facility for the resident to be admitted on [DATE] for a five day stay. The stated they did not think the resident had received a shower during her stay at the facility. In an interview with LVN K on 12/09/25 at 03:45 p.m., she normally worked double weekends and was on duty on the weekend of 11/22/25 and did the admission on Resident #2.In an interview with LVN K on 12/09/25 at 03:45 p.m., she normally worked double weekends and was on duty on the weekend of 11/22/25 and did the admission on Resident #2. She stated this was the first respite admission she had completed. She stated ADON F had sent her a message about the upcoming admission and stated she had received the Hospice faces sheet but stated she had not noticed the staff assignments. She stated she did her admission assessments and stated one of the family members was present during the assessment. She stated the family member stated the resident might be hesitant about allowing them to assist her a lot with changing her clothes and showering but stated she told them if they laid her clothes out the resident could dress herself. She stated a nurse from Hospice came on the day of admission and left her a phone number to call if they needed anything and stated she saw one other person from the Hospice agency come later in the week but was not sure if she was a nurse or caregiver. In an interview with ADON F on 12/10/25 at 8:35 a.m., he stated he had received a message on 11/21/25 that they were receiving Resident #2 on 11/22/25 for respite services for 5 days. He stated he had let LVN K know about the new admission. He stated at that time he was not aware of what services the Hospice agency would provide. He stated when he came in Monday he found out they were missing some documents and had reached out to the hospice agency but stated he did not ask about the hospice aide. He stated this was a new hospice agency they had not worked with before and it was the first respite case he had handled, so he was not sure what was being provided. He stated regardless they still scheduled the resident for showers and provided what care she would allow them to do. In an interview with CNA G on 12/10/25 at 9:05 a.m., she stated Resident #2 was here for 4 or 5 days. She stated she was very independent and required limited assistance. She stated she was scheduled for showers on Monday, Wednesday and Fridays but stated they had offered and she declined. She stated they had assisted her with changing her clothes. She stated she knew she was on hospice services but stated she was not aware of when the Hospice aide was coming. She stated she saw one caregiver come one day but was not sure if she was the hospice aide. She stated they usually know when the hospice aides are coming and how often they are coming. In an interview with Hospice Agency J's Social Worker on 12/10/25 at 11:37 a.m., she stated

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	12/11/2025

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 of 4 residents (Resident #4) reviewed for dignity. The facility failed to ensure Resident #4 had a privacy curtain. This deficient practice could place the resident at risk of not feeling as if they were being treated with dignity and respect while being fed.Findings include:Record review of Resident #4's Face Sheet, dated 12/09/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included major depressive disorder and anxiety. Record review of Resident #4's Quarterly MDS assessment, dated 11/19/25, reflected a BIMS score of 8, a moderate impairment. For ADL care, it reflected the resident required supervision or touching assistance. Record review of Resident #4's Comprehensive Care Plan, dated 12/02/2025, reflected the resident had an impaired cognitive impairment and an intervention included providing the resident a homelike environment. In an interview and observation on 12/09/25 at 12:10 PM, Resident #4 stated she had been in the room for 4 weeks and she did not have a privacy curtain since residing in the room. She stated she needed to change her clothes but had to go into the bathroom because she was concerned about someone walking in on her. The resident was observed to not have a privacy curtain. In an interview on 12/09/25 at 12:30 PM, LVN B stated Resident #4 did not have a privacy curtain and she was supposed to have one for her privacy. She stated she just started working the A-hall and was not sure why the resident did not have a privacy curtain. In an interview on 12/10/25 at 9:48 AM, ADON E and the Administrator was told about Resident #4 not having a privacy curtain in her room, and they stated they were not aware of this. ADON E stated laundry may have removed the curtain to have it cleaned. ADON E stated the resident's roommate had a privacy curtain, this did not help Resident #4 for when anyone came into the room and she was trying the change. They both stated the resident needed a privacy curtain for her privacy and dignity. Record review of the facility's policy on Resident Rights, undated, revealed 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. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.