STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675757	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Pointe	14655 Preston Rd Dallas, TX 75254

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the confidentiality of the residents personal and medical records for five (Residents #3, #4, #5, #6, and #7's) of five residents reviewed for Privacy and Confidentiality. The facility failed to ensure LVN C did not leave Residents #3, #4, #5, #6, and #7's medical information exposed and unattended on top of the nurse's cart on 05/08/2025. This failure could place the residents at risk of their medical information being exposed to unauthorized individuals. Findings included: Resident #3 Record review of Resident #3's Face Sheet, dated 05/08/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #3's Comprehensive MDS Assessment, dated 04/09/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #3's Comprehensive Care Plan, dated 04/28/2025, reflected the resident had disease and conditions which were treated with medications and would be managed by the clinical team. Record review of Resident #3's Physician's Order, dated 04/23/2025, reflected Humalog (fast-acting insulin that lowers blood sugar) U-100 Insulin (insulin lispro) . Per Sliding Scale . Before Meals and At Bedtime . Task(s) to Record: Blood Sugar. Resident #4 Record review of Resident # 4's Face Sheet, dated 05/08/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with type 2 diabetes mellitus. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Comprehensive MDS Assessment, dated 03/10/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident had hypertension and diabetes mellitus. Record review of Resident #4's Comprehensive Care Plan, dated 03/12/2025, reflected the resident had disease process and conditions and would be managed by the clinician team composed of nursing and the physician. Record review of Resident #4's Physician's Order, dated 03/04/2025, reflected VITAL SIGNS: MEDICARE Special Instructions: RECORD COMPLETE SET OF VITAL SIGNS EVERY SHIFT IN EMAR ORDER -PATIENT'S VITAL SIGNS ENTERED ON EMAR WILL SHOW UNDER RESIDENT'S VITAL SIGNS ALSO IN MATRIX (cloud-based EMR used to collect and record medical data) Every Shift DAY 07:00 - 19:00 (7:00 PM), NIGHT 19:00 (7:00 PM) - 07:00. Record review of Resident #4's Physician's Order, dated 03/05/2025, reflected Humulin R Regular U-100 Insulin (insulin regular human) solution; 100 unit/mL; amt: Per Sliding Scale . Task(s) to Record: Blood Sugar. Resident #5 Record review of Resident # 5's Face Sheet, dated 05/08/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed type 2 diabetes mellitus. Record review of Resident #5's Comprehensive MDS Assessment, dated 05/06/2025, reflected the resident as cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #5's Comprehensive Care Plan, dated 03/12/2025, reflected the resident had disease process and conditions and would be managed by the clinician team composed of nursing and physician. Record review of Resident #6s Physician's Order, dated 05/06/2025, reflected DIABETIC: FINGER STICK BLOOD SUGAR . Task(s) to Record: Blood Sugar. Resident #6 Record review of Resident #6's Face Sheet, dated 05/08/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed type 2 diabetes mellitus. Record review of Resident #6's Comprehensive MDS Assessment, dated 05/05/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #6's Comprehensive Care Plan, dated 05/06/2025, reflected the resident had diabetes and the goal was the blood sugar would not exceed 400. Record review of Resident #6's Physician's Order, dated 04/29/2025, reflected insulin lispro . Per Sliding Scale . Before Meals and At Bedtime . Task(s) to Record: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Blood Sugar. Resident #7 Record review of Resident #7's Face Sheet, dated 05/08/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed type 2 diabetes mellitus. Record review of Resident #7's Comprehensive MDS Assessment, dated 04/07/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #7's Comprehensive Care Plan, dated 04/02/2025, reflected the resident had disease process and conditions and would be managed by the clinician team composed of nursing and physician. Record review of Resident #7s Physician's Order, dated 04/15/2025, reflected Humalog Kwik Pen Insulin (insulin lispro) . Per Sliding Scale . Before Meals and At Bedtime . Task(s) to Record: Blood Sugar. Observation on 05/08/2025 at 8:58 AM revealed a piece of paper was left on top of a nurse's cart parked in the hallway. On the piece of paper was Resident #3's name, blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, and blood sugar. On the same piece of paper were Residents #4, #5, #6, and #7's names and their respective blood sugars. The nurse's cart was unattended and was facing the hallway with several staff walking back and forth. In an interview and observation on 05/08/2025 at 9:01 AM, ADON A saw the piece of paper on top of the nurse's cart with Residents #3, #4, #5, #6, and #7's medical information. She flipped the piece of paper so the residents' medical information was not exposed and could not be seen by unauthorized individuals. She stated the residents' information was restricted to unauthorized individuals and it was a HIPAA violation if the information were visible to others that were not providing care to the residents. She said the expectation was for the staff not to leave any personal or medical information about any resident at any time. She said she would coordinate with the DON to do an in-service about privacy and confidentiality. In an interview on 05/08/2025 at 9:06 AM, LVN C stated she left the cart because she administered a treatment to one of the residents. She said the best practice was to secure any information about the residents before leaving the cart. She said the piece of paper had some of the residents' names, vital signs, and blood sugars. She said she should have flipped it or put it inside the drawer before leaving the cart. She said she would be mindful that no information about the resident would be left on top of the cart. In an interview on 05/08/2025 at 12:30 PM, the Administrator stated the staff must make sure the residents' information was not exposed and protected because it was a violation of the residents privacy and confidentiality. She said the vital signs and the blood sugars were medical information and should not be seen by unauthorized individuals. She said the expectation was for all the staff to make sure the personal and medical information of a resident were not left unattended. She said she would collaborate with the DON to do an in-service about privacy and confidentiality. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/08/2025 at 1:08 PM, the DON stated personal and medical information about a resident should not be exposed for everybody to see because they were confidential. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said the staff were expected to provide full privacy and confidentiality of information for all residents. The DON stated she would start an in-service about privacy and confidentiality of the residents' information. Record review of the facility's policy, Confidentiality of Information and Personal Privacy 2001 MED-PASS revised October 2017 revealed Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy . Policy Interpretation and Implementation . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #1, Resident #2 and Resident #3) of five residents reviewed for respiratory care. The facility failed to ensure Residents #1, #2, and #3's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) were properly stored when not in use on 05/08/2025. This failure could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #1 Record review of Resident #1's Face Sheet, dated 05/08/2025, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with chronic respiratory failure with hypoxia (low level of oxygen in the tissues of the body). Record review of Resident #1's Quarterly MDS Assessment, dated 04/10/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had oxygen therapy. Record review of Resident #1's Quarterly Care Plan, dated 04/15/2025, reflected the resident required oxygen therapy related to chronic respiratory failure. Record review of Resident #1's Physician's Orders, dated 01/05/2025, reflected CONTINUOUS O2 AT 2L/MIN TO MAINTAIN O2 SATS > 92% - TITRATE 1L/MIN PROGRESSIVELY AND CHECK O2 SATS UNTIL MAINTAINED AT > 92% - CONTACT PHYSICIAN IF UNABLE TO MAINTAIN O2 SATS >92%. Observation on 05/08/2025 at 8:29 AM revealed Resident #1 was not inside her room. A nasal cannula connected to an oxygen concentrator and was observed spread out on top of her bed; it was not bagged. There was no plastic bag on the resident's side table or on the oxygen concentrator. A sliding board was also at the side of the bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 05/08/2025 at 8:34 AM, the DON said Resident #1 was not inside the room at this time because she went to her therapy. She said the resident could not transfer by herself from bed to wheelchair. She said the resident's mode of transfer was through a sliding board and needed assistance to do the transfer. She then noticed the nasal cannula that was on top of the resident's bed. She said the nasal cannula should be placed in a plastic bag every time the resident was not using it. She said whoever transferred the resident should have placed it in a plastic bag to prevent any respiratory infection. The DON disconnected the nasal cannula from the oxygen concentrator and threw it in the trash can. She said she would get a new one and a plastic bag to store the nasal cannula when not in use. She said she would find out who transferred the resident so she could educate them about bagging the nasal cannula when not in use. She said she would also do an in-service for all the staff providing direct care to the residents. An interview and observation on 05/08/2025 at 12:36 PM, Resident #1 stated she had a therapy session earlier that day. She said she transferred to her wheelchair with the assistance of a staff using a sliding board. She said she was on oxygen for months but cannot remember the exact number of months. She said the staff would help her take off her nasal cannula everytime she was transferred but did not have any idea where they put once she was transferred. Resident #2 Record review of Resident #2's Face Sheet, dated 05/08/2025, reflected an [AGE] year-old male admitted on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #2's Quarterly MDS Assessment, dated 05/03/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated the resident had oxygen therapy. Record review of Resident #2's Quarterly Care Plan, dated 03/12/2025, reflected the resident required oxygen therapy related to chronic obstructive pulmonary disease. Record review of Resident #2's Physician's Orders, dated 03/04/2025, reflected CONTINUOUS O2 AT 2L/MIN TO MAINTAIN O2 SATS > 92% - TITRATE 1L/MIN PROGRESSIVELY AND CHECK O2 SATS UNTIL MAINTAINED AT > 92% - CONTACT PHYSICIAN IF UNABLE TO MAINTAIN O2 SATS > 92%. In an interview and observation on 05/08/2025 at 8:49 AM revealed Resident #2 was in his bed, awake. It was observed that the resident had an oxygen concentration at the bedside with a nasal cannula that was connected to it. The nasal cannula was on the floor. The resident said the nasal cannula had been on the floor since morning and the staff that went inside the room did not notice it. He said he had been using oxygen for months. In an interview on 05/08/2025 at 8:53 AM, LVN B stated he did not notice that the nasal cannula was on the floor when he went inside Resident #2's room. He said it should be in a bag when the resident was not using it. He disconnected the nasal cannula and threw it on the trash can and said he would change it and would get a bag for the new nasal cannula. He said the nasal cannula should be bagged to prevent infection. Resident #3 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Face Sheet, dated 05/08/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with intracranial hemorrhage (bleeding inside the brain) and seizure (involuntary movements that caused convulsions, twitching, and loss of consciousness). Record review of Resident #3's Comprehensive MDS Assessment, dated 04/09/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident had intracranial hemorrhage and seizure. Record review of Resident #3's Comprehensive Care Plan, dated 04/28/2025, reflected the resident had disease and conditions which were treated with medications and would be managed by the clinical team. Record review of Resident #3's Physician's Order, dated 05/08/2025, reflected CONTINUOUS O2 AT 2L/MIN TO MAINTAIN O2 SATS >92% - TITRATE 1L/MIN PROGRESSIVELY AND CHECK O2 SATS UNTIL MAINTAINED AT > 92% - CONTACT PHYSICIAN IF UNABLE TO MAINTAIN O2 SATS > 92%. Observation on 05/08/2025 at 9:10 AM revealed Resident #3 was in his bed with eyes closed. It was observed that the resident had an oxygen concentrator at bedside with a nasal cannula attached to it. The nasal cannula was on top of the side table with the prongs of the nasal cannula touching the table. The nasal cannula was not bagged. In an interview and observation on 05/08/2025 at 9:15 AM, LVN C stated the outgoing nurse told her Resident #3 refused to wear the nasal cannula. She went inside the room and saw the nasal cannula on the table. She said if the resident was not using it, the nasal cannula should be stored in a bag to prevent it from being dirty. She disconnected the nasal cannula and threw it in the trash can. She said she would get a new one a bag to store it. She said she noticed the nasal cannula on the table when she checked on the resident but was not able to address it. In an interview on 05/08/2025 at 12:16 PM, ADON A stated the nasal cannulas should be stored properly if the residents were not using them to prevent cross contamination. She said they should not be left on the bed or on the side table. She said that every time a staff would go inside the room, they should check for the nasal cannula, if the resident was wearing it or if it was on the floor. She said the staff were responsible for ensuring the nasal cannulas were clean every time the residents would use them. She said the expectation was for all nasal cannulas to be stored properly. She said she would coordinate with the DON to do an in-service about respiratory care. In an interview on 05/08/2025 at 12:30 PM, the Administrator stated the nasal cannulas should be bagged to keep them clean to prevent respiratory infection. She said the staff should be mindful that the nasal cannulas were stored properly or monitored frequently. She said she would collaborate with the DON to do an in-service about bagging the nasal cannulas. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/08/2025 at 1:08 PM, the DON said the staff that transferred Resident #1 was a PRN therapist and already signed out. She said she would in-service the therapist when she come back to the facility. She said nasal cannulas were supposed to be in a bag when the residents were not using them to prevent cross contamination and development of infections. She said, come to think of it, the residents with oxygen already had respiratory issues, so it would be prudent to make sure the nasal cannulas were clean to prevent worsening of any respiratory issues they already have. She said the expectation was for the staff to be mindful in making sure nasal cannulas were bagged when not in use and to monitor more frequent if the nasal cannula was on the floor. She said she would conduct an in-service about respiratory care. Record review of the facility's policy Departmental (Respiratory Therapy) - Prevention of Infection revised November 2011 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy . Infection Control Considerations Related to Oxygen Administration . 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47743 Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in a locked cart or under direct observation of authorized staff in an area where residents could access it for one (Wound Care Cart) of one cart reviewed for pharmacy services. The facility failed to ensure that the wound care cart was locked when not in use on 05/08/2025. This failure could place the residents at risk of accessing/opening the cart causing accidental overdose or misuse of medications. Findings included: Observation on 05/08/2025 at 8:12 AM revealed a wound care cart was parked in the hallway near the rehabilitation department. The cart was not locked because the centralized, metal, round lock, located on the upper right side of the cart, was protruding (the round, metal lock needed to be pushed to lock the drawers of the cart). The cart and the drawers were facing the hallway. There were several staff and residents passing the cart. There were staff and residents, as well, inside the rehabilitation department. During an observation and interview on 05/08/2025 at 8:15 AM, the DON saw the cart that was not locked and said she believed it was empty. She opened the cart and saw that it was a wound care cart and had several items used for wound care such as normal saline pink bullets (washes debris away from the wounds, dissolves dried blood, and gets rid of irritants and bacteria), triple antibiotics (prevent infections in minor cuts and scrapes), and wound cleanser solutions (solutions used to remove debris from wound to enhance healing and prevent infections). All the drawers of the cart could be easily opened, and the contents of each drawer could be easily taken. She said the cart should be locked because a resident might open it and take something from it that could cause chocking or allergic reactions. She said a confused resident might took a dressing, swallow it, and choke from it. She said if the cart was empty or was not being used, it should be inside the medication room. In an interview on 05/08/2025 at 12:16 PM, ADON A stated the carts should be locked every time they were left unattended. She said the staff should lock the carts before leaving it to prevent unauthorized individuals from opening them. She said confused residents might open the cart and ingest something to which they were allergic. She said the expectations was the staff using the carts would lock the cart after using them or leaving them unattended. She said she wound coordinate with the DON to do an in-service about the importance of the locking the carts. In an interview on 05/08/2025 at 12:30 PM, the Administrator stated all the carts, nurses' carts, medication aide carts, and the wound care carts, should always be locked to protect the residents. She said the expectation was for the staff to lock the carts. She said she would collaborate with the DON to do an in-service pertaining to locking the carts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/2025 at 1:08 PM, the DON stated, most probably, the night nurses were the ones who last used the cart. She said she would try to find out who left the cart unlocked to educate them. she said she would still do an in-service about locking the carts every time the carts were not within their sight. She said she did not even know how long the cart was left unlocked. She said the expectation was for the staff to lock the carts when left unattended. Record review of the facility's policy, Medication Labeling and Storage 2001 MED-PASS, undated, revealed Policy Statement: The facility stores all medications and biologicals in locked compartments . Policy Interpretation and Implementation . Medication Storage . 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use.