

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Signature Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 14655 Preston Rd Dallas, TX 75254	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each 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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**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 reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one of five residents (Resident #1) reviewed for Reasonable Accommodation of Needs.1. The facility failed to ensure the call light system in Resident #1's room was in a position that was accessible to the resident on 8/12/25. 2. The facility failed to ensure Resident #1 had a call light system that accommodated her physical limitation. These failures could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings include: Record review of Resident #1's face sheet, dated 08/12/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's relevant diagnoses included repeated seizures (uncontrolled jerking) and convulsions. Record review of Resident #1's Quarterly Minimum Data Set assessment, dated 07/24/25, reflected she had a BIMS score of 00, which indicated severe cognitive impairment. ADL care reflected the resident required extensive assistance. Record review of Resident #1's Comprehensive Care Plan, dated 08/12/2025, which was updated after the surveyor observed the concern, reflected the resident had limited range of motion bilateral hand contractures (tightening of joints) and one of the interventions was to use a soft touch call light and place in reach of the resident's left hand. In an observation on 08/12/25 at 10:05 AM, Resident #1 was observed lying in bed, and her light touch pad call light was not within reach. The call light was observed to be hanging on the back wall behind the bed. Both resident's hands appeared contracted. An attempt was made to interview the resident, but she did not appear coherent. In an observation and interview on 08/12/25 at 10:07 AM, LVN S stated Resident #1 required total care and had to be fed. She stated they would have to anticipate the resident's needs by checking on her every two hours. She stated she was unsure if the resident could use the call light button or a call light touch pad. She stated the admitting nurse should have assessed the resident for this. She stated the resident was a full code and would need to contact staff if she was in distress. In an interview on 08/12/25 at 10:30 AM, the DON and ADON were advised Resident #1 did not have her call light within reach and based on the resident's contracted hands, it was unclear if the resident could push the call light button. The DON stated the resident was new to the facility and she did not know if the resident could use a call light button or call light touch pad. She stated an assessment was never completed to determine if the resident could use a call light or touch pad to alert staff if she was in distress. The DON stated the nursing staff admitting the resident should have assessed for this when the resident was admitted to the facility. She stated whoever the nurse on duty at the time the resident was admitted, should have completed this task, so there was not a particular nurse assigned, and she could not recall who admitted the resident. The DON stated the resident was a full code and would require assistance if she had any distress. She stated they checked on the resident at least every two hours. She stated they would assess the resident to see if she was cognitively able to use the call light touch pad, and care plan it if the resident was not able to use the call light button or call light touch pad. She stated there was no risk for the resident because they checked on the resident at least every two hours to ensure she was not in distress. In an interview on 08/12/25 at 12:50 PM, the Administrator was advised of Resident #1 not being assessed for being able to use a call light and he stated he had his maintenance director install a call light touch pad for the resident today, and they were able to assess the resident was able to use the call light touch pad to alert staff for any assistance. He stated the call light touch pad was needed for the resident to ensure she could contact staff if she was in distress. Record review of the facility's policy on Call System, Residents (September 2022), reflected Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident free from physical restraints not required to treat the residents' medical symptoms as was possible for one of five residents (Resident #2) reviewed for physical restraints. The facility failed to ensure Resident #2 had physician orders for the for the bolster pads (bed padding) attached to the mattress on her bed. This failure could failure could place residents at risk of not having an environment that was free of restraints which could result in injury. Findings include:Record review of Resident #2's face sheet, dated 08/12/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's relevant diagnoses included muscle weakness and lack of coordination. Record review of Resident #2's Quarterly Minimum Data Set assessment, dated 07/24/25, reflected she had a BIMS score of 00, which indicated severe cognitive impairment. ADL care reflected the resident required extensive assistance. Record review of Resident #2's Comprehensive Care Plan, dated 07/18/25, reflected the resident was a fall risk related to her recent admission to the community, but the interventions did not include the bolster pads. Record review of Resident #2's physician orders, dated 08/12/25, reflected no physician orders for the bolster pads. In an observation on 08/12/25 at 10:10 AM, Resident #2 was observed lying in bed. The resident's bed had bolster pads, that measured approximately six inches in height and six inches in thickness. The resident could not freely exit the bed. The pads were placed on all sides of the resident's bed. In an interview on 08/12/25 at 10: 45 AM, the DON and ADON stated Resident #2 transferred from another facility and had the bolster pads when she arrived. They stated the resident did not have physician orders for the bolster pads, and they stated they did not think it was not a risk for the resident. They stated hospice provided the resident the bolster pads, but they were unsure why the resident required it. They stated she would contact the physician to obtain physician orders for the resident to have the equipment. She stated she did not know physician orders were required for this equipment. In an interview on 08/12/25 at 12:50 PM, the Administrator was advised of Resident #2 not having physician orders for the bolster pads on her mattress and he stated he did not think there was any risk for the resident having the equipment. He stated Hospice provided the equipment to the resident prior to her being transferred to the facility. Record review of the facility's policy USE OF RESTRAINTS AND SECLUSION (11/02/15) reflected All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraints or seclusion of any form, to include coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member or others, and must be discontinued at the earliest possible time. Interpretations and Definitions: 'Physical restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted.</p>		