

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 11/25/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one of six residents (Resident #4) reviewed for dignity. The facility failed to conceal Resident #4's gall bladder bag lying in public view. This failure placed residents at risk of not having their right to a dignified existence and self-determination maintained. Findings included: Record review of Resident #4's Face Sheet, dated 10/02/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnosis of Gastro-Esophageal Reflux disease (digestive disease). Record review of Resident #4's Quarterly MDS Assessment, dated 8/11/25, reflected Resident #4 had a BIMS score of 99 (unable to complete the interview). The Quarterly MDS Assessment reflected an active diagnosis of Acute Cholecystitis (inflammation of gall bladder). Record review of Resident #4's Physician Order, dated 10/02/25, reflected RESIDENT HAS ORDER FOR C-TUBE (GALLBLADDER TUBE) PLEASE ENSURE BAG IS COVERED WITH PILLOWCASE FOR PRIVACY/DIGNITY. In an observation and interview on 10/02/25 at 10:18 AM, ADON M and the Surveyor observed Resident #4's gall bladder bag on the bed near her and she did not have a privacy bag. ADON M stated the resident needed a privacy bag because it was a dignity issue. He stated he did not know why she did not have one. In an interview on 10/02/25 at 10:22 AM, LVN O was told by the Surveyor that Resident #4 was observed to have a gall bladder bag sitting on top of the bed, uncovered. She stated the resident needed the bag covered for privacy. She stated she made rounds this morning but did not check to ensure the bag was covered. In an interview on 10/02/25 at 10:39 AM, ADON Y was told by the Surveyor that Resident #4 was observed to have a gall bladder bag sitting on top of the bed, uncovered. She stated she went to the resident's room and confirmed she did have a gall bladder bag exposed. She stated the nursing staff normally used a pillowcase to cover it. She stated it should be covered for infection control, privacy, and for the resident's dignity. In an interview on 10/02/25 at 12:07 PM the DON stated ADON Y told her about Resident #4 not having a privacy bag for her gall bladder bag. She stated the resident should have been provided with a privacy bag or a pillowcase to cover the bag. She stated the bag was needed to protect the resident's dignity. Record review of the facility's policy on Dignity, dated September 2022, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p>

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 - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</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 observation, interview, and record review the facility failed to ensure the nurse call system was assessable for three of six residents (Resident #1, #2, and #3) reviewed for call systems access. The facility failed to ensure the call light system in Resident #1, #2, and #3's rooms was in a position that was accessible to the residents on 10/02/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/02/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included lack of coordination. Record review of Resident #1's Quarterly MDS assessment, dated 9/29/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 8/28/25, reflected no plan of care for ADL. In an observation on 10/02/25 at 08:25 AM Resident #1 was observed lying in bed. Her call light was on the floor near the bedside table and out of reach. 2. Record review of Resident #2's Face Sheet, dated 10/02/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Gastro-Esophageal Reflux disease (digestive disease). Record review of Resident #2's Quarterly MDS assessment, dated 09/21/25, reflected a BIMS score of 3 (severe cognitive impairment). For ADL care, it reflected the resident required total assistance. Active diagnosis included gastrointestinal hemorrhage. Record review of Resident #2's Comprehensive Care Plan, dated 08/21/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation and interview on 10/02/25 at 08:28 AM Resident #2 was observed lying in bed. His call light was on the floor alongside the left bed rail, and out of reach of the resident. The resident stated he needed to urinate and needed assistance, but he did not know where his call light was located. The surveyor told him he would notify the nursing staff. 3. Record review of Resident #3's Face Sheet, dated 10/02/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included difficulty walking and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 09/24/25, reflected a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required substantial assistance. Record review of Resident #3's Comprehensive Care Plan, dated 09/24/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/02/25 at 08:29 AM Resident #3 was observed lying in bed. Her call light was on the floor, slightly under the nightstand, and out of reach. In an interview on 10/02/25 at 08:35 AM, LVN E was shown pictures by the Surveyor of Resident #1, #2, and #3's call lights and where they were found. She stated the call lights needed to be placed within reach of the resident in case they needed help. She stated the residents may have knocked them down when they were moving in bed. In an interview on 10/02/25 at 11:35 AM, ADON N was shown pictures by the Surveyor of Resident #1, #2, and #3's call lights and where they were found. She stated the call lights needed to be placed within reach of the resident in case they needed help. She stated she in-serviced the staff on call lights today. She stated all staff should be checking to ensure call lights were within reach of the resident when they completed their rounds. In an interview on 10/02/25 at 12:07 PM, the DON stated she had been at the facility since September 2025. She was told about Resident #1, #2, and #3. She stated she expected call lights to be within reach. She stated she was told about this by ADON N. She stated she met with maintenance and got a supply of call light clips and ensured the call lights were clipped to the bed, and she also in-serviced staff on ensuring call lights were within reach and ensuring the call lights were clipped. She stated if the call light was not within reach of the resident they would not be able to contact anyone for help. Record review of the facility's policy on Answering Call Lights, dated September 2022, revealed The purpose of this policy is to assure timely responses to the resident's requests and needs. Ensure the call light is accessible to the resident when in bed.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>(continued on next page)</p>

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<p>F 0604</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 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 two of six residents (Resident #5 and #6) reviewed for restraints. The facility failed to ensure Resident #5 and Resident #6 had physician orders for the bolster mattresses on their beds. This failure could prevent the residents from having an environment that was free from physical restraints. Findings included: 1. Record review of Resident #5's Face Sheet, dated 10/02/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #5's Quarterly MDS assessment, dated 8/27/25, reflected she had a BIMS score of 11 (moderate cognitive impairment). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of muscle spasms. Record review of Resident #5's Comprehensive Care Plan, dated 10/02/25, reflected the resident was a fall risk and an intervention included the use of a bolster mattress. Record review of Resident #5's physician orders, dated 10/02/25, reflected no physician orders for the bolster mattress. In an observation on 10/02/25 at 8:46 AM, Resident #5 was observed lying on a bolster mattress on her bed. In an interview and observation on 10/02/25 at 10:39 AM, ADON Y was told by the Surveyor that Resident #5 was observed lying on a bolster mattress. She stated the resident needed the bolster mattress for her care and she should have physician orders for the device. She stated she checked the physician orders for Resident #5 and did not find any orders for the device but would ensure physician orders were obtained because it was needed. 2. Record review of Resident #6's Face Sheet, dated 10/02/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included repeated falls and unsteadiness on feet. Record review of Resident #6's Quarterly MDS assessment, dated 6/30/25, reflected she had a BIMS score of 99 (unable to complete the interview). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of muscle weakness. Record review of Resident #6's Comprehensive Care Plan, dated 4/07/25, did not indicate a care plan for the bolster mattress. Record review of Resident #6's physician orders, dated 10/02/25, reflected no physician orders for the bolster mattress. In an interview and observation on 10/02/25 at 10:52 AM, LVN O observed Resident #6 lying on a bolster mattress. She stated the resident had pressure wounds on her bottom and needed the mattress. She was told by the Surveyor that physician orders were not found for the resident in the system of records for the use of the bolster mattress. She stated physician orders were needed for all devices. In an interview on 10/02/25 at 11:00 AM, ADON Y was told by the Surveyor that Resident #6 was observed lying on a bolster mattress. She stated the resident needed the bolster mattress for her care and she should have orders for the device. She stated she checked the physician orders for Resident #6 and did not find any physician orders for the device and she was not sure why they did not have one on file. She stated she would submit the request for physician orders. In an interview on 10/02/25 at 12:07 PM the DON stated she was told by ADON Y about Resident #5 and #6 having bolster mattresses but no physician orders. She stated they were working on obtaining physician orders for the devices. She stated physician orders were needed to ensure the devices were not a risk to the residents. The facility's policy Bed Safety, dated 12/2007, reflected The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.).</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of three residents (Resident #6) reviewed for respiratory care. The facility failed to ensure Resident #6's nebulizer mask was properly stored in a bag when not in use on 10/02/25. This failure could place the resident at risk for respiratory infection and not having his respiratory needs met. Findings included: Record review of Resident #6's Face Sheet, dated 10/02/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included acute respiratory failure (shortness of breath). Record review of Resident #6's Quarterly MDS assessment, dated 6/30/25, reflected he had a BIMS score of 99 (unable to complete the interview). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of acute respiratory failure. Record Review of Resident #6's physician orders, dated 10/02/25, reflected IPRATROP-ALBUT 0.5MG-2.5MG/3ML 1 vial inhale orally every morning and at bedtime related to ACUTE AND CHRONIC RESPIRATORY FAILURE VIA NEBULIZER. In an interview and observation on 10/02/25 at 10:52 AM, LVN O and the Surveyor observed Resident #6 with her Nebulizer mask unbagged in her nightstand. She stated the mask should be bagged to avoid the resident getting an infection. She stated she normally checked to ensure her mask was bagged but somehow overlooked it this morning. In an interview on 10/02/25 at 12:07 PM, the DON stated LVN O and ADON Y told her about Resident #6 not having her nebulizer mask bagged when not in use. She stated LVN O stated she had forgotten to bag the mask after the resident had used it this morning. She stated the resident was provided with a new mask. She stated bagging the mask was necessary to avoid an infection. Review of the facility's policy Oxygen Administration, dated 09/2024, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident. 3. Assemble the equipment and supplies as needed.</p>		