

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  12/03/2025
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 0583  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Keep residents' personal and medical records private and confidential.  (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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to confidentiality of his or her personal and medical records for eight (Residents #1, #5, #6, #7, #8, #9, #10, and #11) of twelve residents reviewed for privacy and confidentiality. The facility failed to ensure LVN A closed, locked, or minimized her laptop's monitor and did not leave Residents #1, #5, #6, #7, #8, #9, #10, and #11's medical information exposed and unattended on top of the nurse's cart on 12/03/2025. This failure could place the residents at risk of their medical information being accessed by unauthorized individuals. Findings included: Resident #1 Record review of Resident #1's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with malignant (conditions that are dangerous to health) neoplasm (abnormal growth of tissue in the body) of the colon (part of the large intestine) and hypertension (high blood pressure). Resident #5 Record review of Resident #5's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with intracranial hypotension (abnormally low pressure in the skull). Resident #6 Record review of Resident #6's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cardiac arrest (heart attack). Resident #7 Record review of Resident #7's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with pneumonitis (swelling of the lung tissue). Resident #8 Record review of Resident #8's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with acute respiratory failure (inability of the lungs to provide adequate oxygen). Resident #9 Record review of Resident #9's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with heart failure (heart muscle is unable to pump enough blood to the body). Resident #10 Record review of Resident #10's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's disease (movement disorder). Resident #11 Record review of Resident #11's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with congestive heart failure. Observation on 12/03/2025 at 9:16 AM revealed an untitled piece of paper was left on top of a nurse's cart parked in the hallway. On the piece of paper was Resident #1, #5, #6, #7, #8, #9, #10, and #11's blood pressure, pulse rate, and oxygen saturation. It was also observed that the laptop on top of the same nurse's cart was open. The monitor of the open laptop showed Residents #1, #5, #6, #7, #8, #9, #10, and #11's pictures and that the residents were on skilled nursing. The nurse's cart was unattended and was facing the hallway with several staff walking back and forth. During an interview on 12/03/2025 at 9:18 AM, LVN A stated she left the cart because she went to attend to a resident who needed assistance. She said the best practice was to secure any information about the residents before leaving the cart unattended. She flipped that paper and closed her laptop. She said the piece of paper had some of the residents' vital signs while the laptop showed the names of the residents, their pictures, and that they were on skilled nursing. She said she should have secured the paper and closed the laptop she was using before leaving the cart. She said she would be mindful that no information about the resident would be exposed. In an interview on 12/03/2025 at 11:59 AM, the DON stated personal and medical information about a resident should be secured to avoid a HIPAA violation. She said the information should not be exposed for everybody to see because it was confidential. She said the health information should be protected and could only be shared to the residents, the responsible parties, and the providers. She said the information could not be seen by staff that had nothing to do the residents' care, visitors, and even vendors. 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. In an interview on 12/03/2025 at 1:08 PM, the Administrator stated the staff must make sure the residents' information was not exposed and was protected because it was a violation of the residents' privacy and confidentiality. She said the vital signs, their pictures, and the level of care they were receiving 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. In an interview on 12/03/2025 at 3:00 PM, ADON H stated the laptop should have been closed and the paper should have been</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for three (Residents #2, #3, and #4) of ten residents reviewed for medication storage. 1. The facility failed to ensure a tube of zinc oxide (cream used to treat skin irritations, diaper rash, and other skin conditions) was not left in Resident #2's room on 12/03/2025. 2. The facility failed to ensure a tube of zinc oxide was not left in Resident #3's room on 12/03/2025. 3. The facility failed to ensure tubes of zinc oxide and a container of wound cleanser were not left in Resident #4's room on 12/03/2025. 4. The facility failed to ensure LVN B did not leave the solution for breathing treatment on top of the nurse's cart unattended on 12/03/2025. These failures could place the residents at risk of accidental overdose or misuse of medications. Findings included: 1. Record review of Resident #2's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #2's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was always incontinent (uncontrolled) for bladder and bowel. Record review of Resident #2's Comprehensive Care Plan, dated 11/28/2025, reflected the resident had urinary and bowel incontinence and one of the interventions was to apply barrier cream after each episode of incontinence. Record review of Resident #2's Physician Order, dated 11/27/2025, reflected APPLY SKIN BARRIER CREAM/OINTMENT TO SACRAL (bone located at the base of the spine)/COCCYX (tailbone)/BUTTOCK Q SHIFT AND PRN AFTER INCONTINENT CARE. every shift AND as needed. Record review of Resident #2's Assessment Notes, on 12/03/2025, reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. In an observation and interview on 12/03/2025 at 9:30 AM revealed Resident #2 was in his bed, awake. It was observed that there was a tube of zinc oxide on top of the resident's dresser. The resident said the staff used it every time they would clean and change him. He said the tube had always been on top of his dresser since he was admitted to the facility. During an observation and interview on 12/03/2025 at 9:56 AM, LVN C stated the zinc oxide should not be left inside the resident's rooms for safety reasons. She said residents might misuse it or mistakenly use it as a toothpaste. She went inside Resident #2's room and saw the tube of barrier cream. She said the aides would use it after incontinent care. She said the barrier ointment had zinc oxide in it and was also used to prevent skin issues, making it a form of medication. She took the barrier ointment and said it should be inside the cart. 2. Record review of Resident #3's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #3's Comprehensive MDS Assessment, dated 10/01/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #3's Comprehensive Care Plan, dated 10/01/2025, reflected the resident had urinary and bowel incontinence and one of the interventions was to apply barrier cream after each episode of incontinence. Record review of Resident #3's Physician Order, dated 09/10/2025, reflected APPLY SKIN BARRIER CREAM/OINTMENT TO SACRAL/COCCYX/BUTTOCK Q SHIFT AND PRN AFTER INCONTINENT CARE. every shift AND as needed. During an observation and interview on 12/03/2025 at 9:09 AM revealed Resident #3 was in her bed, awake. Observation revealed a tube of zinc oxide was at the resident's side table. When asked who left the zinc oxide on her side table, the resident did not reply. In an interview on 12/03/2025 at 1:37 PM, CNA E stated zinc oxide should not be within the reach of the residents because the residents might be confused and eat it or spread it on the whole body. She said the resident might be sensitive to the ingredient of the zinc oxide. She said if a resident ate it, it may cause stomach upset. 3. Record review of Resident #4's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with pressure ulcer (wound on the skin caused by prolonged pressure to specific area of the body) to the left buttock. Record review of Resident #4's Comprehensive MDS Assessment, dated 10/02/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had a pressure</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to establish and 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 two (Resident #1 and Resident #2) of twelve residents reviewed for infection control. 1. The facility failed to ensure CNA E performed hand hygiene during Resident #1's incontinent care on 12/03/2025. 2. The facility failed to ensure LVN C wore a gown for EBP while disconnecting Resident #2's IV on 12/03/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings include: 1. Record review of Resident #1's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with kidney failure (kidneys stop working). Record review of Resident #1's Comprehensive MDS Assessment, dated 11/10/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #1's Comprehensive Care Plan, dated 11/19/2025, reflected the resident had incontinence and one of the interventions was to provide pericare after each incontinent care. An observation on 12/03/2025 at 8:43 AM revealed CNA E was about to do Resident #1's incontinent care. CNA E washed her hands and then put on a pair of gloves. She cleaned the perineal (area between the legs) area using the front to back technique. She took off her gloves and put on a new pair of gloves. She cleaned the perineal area again, took off her gloves, and put on a new pair of gloves. She rolled the resident and cleaned her bottom. After cleaning the bottom, she took off her gloves and put on a new pair of gloves. She cleaned the resident's bottom again. After cleaning, she then changed her gloves again, took the brief, put it on the resident's bottom, and fixed it. She did not sanitize her hands when she changed her gloves several times. In an interview on 12/03/2025 at 8:56 AM, CNA E stated their hands should be sanitized first before putting on a new pair of gloves to make sure the hands were clean before touching the new pair of gloves. She said she needed to sanitize her hands in between changing of gloves to prevent cross contamination, and eventually infection. She said she knew she should sanitize her hands in between changing of gloves but forgot to do so. 2. Record review of Resident #2's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with infection due to right knee prosthesis. Record review of Resident #2's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was on antibiotics. Record review of Resident #2's Comprehensive Care Plan, dated 11/28/2025, reflected the resident had an infection to right knee one of the interventions was to administer medications as ordered. Record review of Resident #2's Physician Order, dated 11/28/2025, reflected Enhanced Barrier Precautions: Providers and Staff must wear gloves and a gown when performing High-Contact resident care activities every shift for Prophylaxis (preventive care). Record review of Resident #2's Physician Order, dated 12/02/2025, reflected Penicillin G (gold standard: designation that reflects the effectiveness of the antibiotic) Potassium 4 Mill. Units Intravenous Every 4 hours every 4 hours for Prophylaxis until 12/30/2025 23:59 Administer Medication via IV bag not IV Push. During an observation and interview on 12/03/2025 at 9:38 AM reflected Resident #2 was in his bed, awake. It was observed that he had an IV connected to a PICC line to his left arm. He said he was on antibiotics because he just had a surgery. He said the nurse would be disconnecting the IV because it was already done. An observation on 12/03/2025 at 9:41 AM revealed LVN C was about to disconnect Resident #2's IV. She closed the door, washed her hands, put on a pair of gloves and proceeded to disconnect the resident's IV. She did not wear a gown when she disconnected the IV. It was observed that there was a sign outside the door indicating to wear a gown central line use or care. In an interview on 12/03/2025 at 9:49 AM, LVN B stated Resident #2 had an IV and EBP was required. She said she did not know why she forgot to wear a gown when she disconnected the resident's IV. She said the gown was needed basically to prevent transmission of microorganisms from one resident to another. She said she would wear a gown the next time she would connect a new IV as well as when she would disconnect it. In an interview on 12/03/2025 at 11:59 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said hands should be sanitized in between changing gloves and if the nurse was disconnecting an IV, then a gown should be worn. She said if a resident had an IV, the staff should wear a</p>		