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	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Pointe	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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(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	**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 three of ten residents (Residents #1, #2, and #3) reviewed for resident rights. The facility failed to ensure the call light system in Residents #1, #2, and #3's rooms were adequately equipped to allow residents to call for staff assistance through a communication system on 11/04/25. 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 11/04/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included difficulty walking and muscle weakness. Record review of Resident #1's Quarterly MDS assessment, dated 9/30/25, reflected a BIMS score of 03, which indicated severe cognitive impairment. For ADL care, it reflected the resident was dependent on staff to provide all care. She had active diagnoses of a lack of coordination and muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 9/25/25, reflected the resident was a fall risk, and included an intervention of ensuring call light was available to the resident. In an interview and observation on 11/04/25 at 8:19 AM, Resident #1's call light was observed hanging from the side of the bed, on the floor and out of her reach. She was asked if she knew where her call light was located and she stated no. In an interview on 11/04/25 at 10:58 AM, LVN F stated the DON told her about Resident #1 not having her call light within her reach. She stated the call light should be in reach of the resident in case she needed assistance and for her safety. She stated they did rounds every 1-2 hours, and they checked to ensure call lights were in the residents' reach. She stated they were supposed to clip it to ensure that it did not fall on the floor. In an interview on 11/04/25 at 11:22 AM, CNA D stated she was told by one of the nurses that Resident #1 did not have her call light within her reach. She stated she did clip the call light to the resident's gown in the morning prior to breakfast. She stated she checked to ensure call lights were within the residents' reach throughout her shift. She stated there were a lot of risk if the call light was not within reach of the resident. She stated the resident would not be able to contact anyone if help was needed. 2. Record review of Resident #2's Face Sheet, dated 11/04/25, 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 #2's Quarterly MDS assessment, dated 8/29/25, reflected a BIMS score of 0, which indicated severe cognitive impairment. For ADL care, it reflected the resident required total assistance. She had active diagnoses of muscle wasting and age-related physical debility. Record review of Resident #2's Comprehensive Care Plan, dated 6/03/25, reflected the resident was a fall risk. In an interview and observation on 11/04/25 at 8:30 AM, Resident #2's call light was observed hanging from the side of the bed, on the floor and out of her reach. She was asked if she knew where her call light was located and she stated no. 3. Record review of Resident #3's Face Sheet, dated 11/04/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and muscle wasting. Record review of Resident #3's Quarterly MDS assessment, dated 6/10/25, reflected a BIMS score of 3, which indicated severe cognitive impairment. For ADL care, it reflected the resident required substantial assistance. She had an active diagnosis of chronic pain. Record review of Resident #3's Comprehensive Care Plan, dated 11/04/25, which was updated after surveyor observation, reflected the resident was resistive to care and often removed her call light. None of the interventions referenced ways to keep the resident's call light on the bed. In an observation on 11/04/25 at 8:32 AM, Resident #3's call touch pad was observed on the floor, near the back wall, and out of her reach. In an interview and observation on 11/04/25 at 8:32 AM, the DON was shown the call lights for Resident #2 and Resident #3 on the floor and not within reach of the residents. She stated the call lights should be in reach of the residents so they could contact staff if they need assistance. She stated she had constantly coached her staff to ensure the call lights were clipped near the residents every time they made their rounds. She stated she constantly reminded them to check for this throughout their shift. In an interview on 11/04/25 at 8:55 AM, the Administrator was advised of Residents #1, #2, and #3 not having their call lights within their reach. She stated they had constantly tried to engrain in the nursing staff's brain to check for this every time they provided care to the residents and when they made their rounds. She stated they were trying to change the culture at the facility because they had identified this as a problem when they