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	01/14/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident had the right to receive written notice, including the reason for the change, before the resident's room was changed for 1 of 5 residents (Resident #1) reviewed for room change notifications. The facility failed to ensure Resident #1's Resident Representative was notified of the room change prior to Resident #1 being moved from room [ROOM NUMBER]B to room [ROOM NUMBER]B on 11/03/25. This deficient practice could place the resident at risk of experiencing anxiety and depression about moving to a new environment. Findings included: Record review of Resident #1's Face Sheet, dated 01/14/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses of depression and anxiety. Resident #1 was not his own Responsible Party Record review of Resident #1's Quarterly MDS Assessment, dated 10/15/25, reflected the resident had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of dementia (memory and thinking decline) and depression. Record review of Resident #1's Room Change notification revealed the form was signed by Resident #1 on 10/29/25, who was not his own RP, and not the RR. The notification stated the resident was moved to a Medicaid room on the Medicaid floor. The resident was residing on the 3rd floor and was moved to the 4th floor. Record Review of Resident #1's admission forms signed on 07/14/25, revealed the RR signed as the party consenting to the resident to receive treatment at the facility. In an interview on 1/14/26 at 9:15 AM, Resident #1's RR stated she was not made aware of the resident's room change. She stated she had received a call from the resident advising her the facility was moving him to a different room on a different floor. She stated she was the resident's RR for a reason, and she should have been notified of any changes involving the resident. She stated she had medical power of attorney to make decisions on the resident's care. She did not indicate if the facility or Resident #1 advised her of the reason for the room change. In an interview on 1/14/26 at 12:30 PM, Resident #1 stated he had a form shoved into his face telling him he was going to be moved to the 4th floor. He stated he felt as if he was being coerced into signing the paper because they made it seem as if he did not have a choice. He stated he contacted the RR, and she was frustrated because the facility had him sign the document instead of contacting her. Resident #1 stated he was not sure why he was being moved to another room. In an interview on 1/14/26 at 11:00 AM, the Administrator and Chief Nursing Operator were told about Resident #1's RR not being notified of the room change. The Administrator stated she was trained if the resident was of sound mind, the resident could be informed of the change request, and the Resident could inform the RR. She stated the RR would only be notified if the Resident was not coherent. The Administrator and CNO stated the resident had the right to make decisions regarding his care. The Administrator stated staff went to the resident and notified him of the room change and he stated he would notify the RR. The Administrator stated the Surveyor wanted the facility not to respect the rights of the resident by not allowing him to make (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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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decisions regarding his care. The CNO stated they would change the RR to Resident #1 to prevent having to contact the RR on file for any care regarding the resident because he was coherent. The Administrator stated they had moved all Medicaid Residents to the fourth floor. Review of the facility's policy on Resident Representative (02/2021) revealed The facility treats the decisions of the resident representative as the decisions of the resident to the extent delegated by the resident or to the extent required by the court, in accordance with applicable law.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify, consistent with his or her authority, the resident representative when there was a need to alter treatment significantly for 1 of 5 residents (Resident #1) reviewed for Resident Representative notification of treatment change. The facility failed to ensure Resident #1's Resident Representative was notified of the medication, Tramadol, prescribed to the resident on on 11/18/25. This deficient practice could place the resident at risk of taking medication that may be harmful to the resident. Findings included: Record review of Resident #1's Face Sheet, dated 01/14/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had a diagnosis of dementia (memory and thinking decline). Record review of Resident #1's Quarterly MDS Assessment, dated 10/15/25, reflected the resident had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of dementia (memory and thinking decline) and depression. Record review of Resident #1's Physician orders, dated 01/14/26, reflected the Tramadol HCl 50 MG by mouth every 8 hours as needed for pain, prescribed on 11/18/25. Record Review of Resident #1's admission forms signed on 07/14/25, revealed the RR signed as the party consenting to the resident to receive treatment at the facility. In an interview on 1/14/26 at 9:15 AM, Resident #1's RR stated she was not made aware of the resident receiving Tramadol for his pain. She stated as his RR she should have been made aware of the physician orders for the resident. She stated she spoke with the Administrator and was advised they did not have to contact the RR because the resident was of sound mind. The RR stated she thought because this was a narcotic, the RR should have been notified of the medication being administered to the resident. The RR stated she was concerned about the resident being given the pain medication because he was a recovering alcoholic. In an interview on 1/14/26 at 11:00 AM, the Administrator and Chief Nursing Operator were told about Resident #1's RR not being notified of the medication being prescribed to Resident #1. The Administrator stated she was trained if the resident was of sound mind, the resident could make decisions regarding his care and the resident was in pain. She stated the RR would only be notified if the Resident was not coherent. The Administrator and CNO stated the resident had the right to make decisions regarding his care. The Administrator stated the Surveyor wanted the facility not to respect the rights of the resident by not allowing him to make decisions regarding his care. The CNO stated they would change the RR to Resident #1 to prevent having to contact the RR on file for any care regarding the resident because he was coherent. In an interview on 01/14/26 at 11:45 AM the DON, and ADON S stated they were not aware if consent from Resident #1's RR would be required if the resident was of sound mind. They stated they tried to ensure the RR was made aware of the resident's care because she was constantly in communication with the nursing staff. Review of the facility's policy on Resident Representative (02/2021) revealed The term Resident Representative is defined as: An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision -making; access medical, social or other personal information of the resident ; manage financial matters, or receive notifications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 6 residents (Resident #1 and #2) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #1's fingernails were trimmed. The facility failed to ensure Resident #2 received her scheduled bed baths for January 2026 and December 2025. These failures could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem.Findings Included:Record review of Resident #1's Face Sheet, dated 01/14/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses of Hemiplegia affecting left dominant side (paralysis) and contracture of left hand (permanent tightening of tendons). Record review of Resident #1's Quarterly MDS Assessment, dated 10/15/25, reflected the resident had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of Hemiplegia affecting left dominant side and contracture of left hand (permanent tightening of tendons). The resident required total assistance for ADL care. Record review of Resident #1's Comprehensive Care Plan, dated 12/17/25, reflected the resident had an ADL self-care deficit and the resident was totally dependent on staff to provide ADL care. Record review of the Facility's Grievance log for December 2025 revealed Resident #1 filed a grievance on 12/17/25 about his fingernails not being trimmed. Observation of the pictures dated 01/05/26 provided by Resident #1's RR revealed the resident's fingernails on both hands being at least a half-inch in length and some of the fingernails had thick black substance under them. In an interview on 1/14/26 at 9:12 AM, Resident #1 stated he had been requesting to have his nails trimmed for weeks. He stated the long nails were digging into the palm of his left hand because it was contracted. He stated he had first complained about his nails needing to be trimmed sometime in December to a CNA (unknown) and he was told a nurse would trim them. He stated he told a male nurse (unknown) and was told they would be trimmed. He stated he complained to someone checking on residents and he finally got them trimmed on or about 1/07/26. In an interview on 1/14/26 at 9:15 AM, Resident #1's RR stated she had been attempting to get the resident's fingernails trimmed for weeks and was told by the nursing staff and Administrator it would be done, but they never did. She stated they finally trimmed his fingernails in January 2026. Record review of Resident #2's Face Sheet, dated 01/14/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis of Hemiplegia affecting left dominant side (paralysis) Record review of Resident #2's Quarterly MDS Assessment, dated 12/31/25, reflected the resident had a severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of Hemiplegia affecting left dominant side (paralysis) and physical debility. The resident required total assistance for ADL care. Record review of Resident #2's Comprehensive Care Plan, dated 10/02/25, reflected the resident was at risk for skin breakdown and the resident was totally dependent on staff to provide ADL care. Record review of Resident #2's clinical records on 01/14/26, revealed 1 shower form dated 10/17/25 uploaded in the facility's system of record for the resident. After this was brought to ADON M and the DON's attention, the facility provided shower forms for December 2025 and January 2026. Bed bath forms were received for 12/05/25, 12/11/25, 12/16/25 (refused because water was cold), 12/20/25, 01/02/26, and 01/10/26. In an interview on 1/14/26 at 12:56 PM, Resident #2 stated she really liked getting bed baths, but she had not been receiving them consistently. She stated she only received one bed bath last week. She stated she also needed her hair to be washed. She stated she needed her bed baths and had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not refused any. In an interview on 1/14/26 at 1:07 PM, LVN R stated she was the charge nurse for the hall of Resident #1. She stated she was unaware of the resident's nails not being trimmed. She stated when the resident received his showers, the CNA should also check to ensure his fingernails were trimmed. She stated the resident's showers were completed by the 2PM - 10 PM staff. She stated the resident not having his fingernails trimmed could result in his fingernails digging into his skin on his left contracted hand. She stated Resident #2's showers or bed baths were provided by the evening CNAs. She stated the resident was scheduled for showers on Tuesday, Thursday, and Saturday. She stated it was her and the ADON's responsibility to ensure residents received their showers or bed baths. She stated if the resident did not receive them, she could have skin breakdown. In an interview on 1/14/26 at 1:12 PM, ADON M stated the charge nurse was responsible for ensuring residents received their showers or bed baths and fingernails trimmed. He stated he was not aware of Resident #1's fingernails not being trimmed. He was told by the Surveyor of Resident #2 stating she was not receiving her scheduled bed baths. He stated the CNAs were required to complete showers and bed baths whenever the resident was scheduled for their shower. He stated the charge nurse was responsible for signing the form, and if the resident refused the charge nurse was responsible for encouraging the resident to take a shower and if they still refused, the charge nurse was to contact the RR or emergency contact. He stated all shower forms were to be uploaded in the residents' clinical records. He was told by the Surveyor there was only one shower sheet uploaded for the resident, which was on 10/17/25. He stated he would research where the showers sheets were at for the resident. He stated if the resident did not receive her showers she could have skin breakdown. He stated the residents did not have an assigned CNA for their halls and the CNAs rotated halls daily. He stated LVN R was the charge nurse for the residents and was responsible for ensuring residents received their bed baths or showers. In an interview on 1/14/26 at 1:19 PM, the DON stated the CNAs were to complete shower sheets, the nurses were to sign them, and then they are sent to medical records to be scanned and uploaded into the resident records. She stated if the resident did not receive their scheduled bed baths or showers, they could have infections and skin breakdown. She stated the ADONs should be checking to ensure the residents receive their showers or bed baths. She was told about Resident #2 complaining of not receiving her bed baths as scheduled. She stated she had observed the shower forms for December 2025 and January 2026. She was told about Resident #1's grievance of not getting his fingernails trimmed on 12/17/25, and the length of time between the time the resident had made a grievance to when the resident had stated his nails were finally trimmed on 1/07/26, and she stated she did not know why it took so long because she was out the office. She stated she spoke with the nurses and ADONs about staying on top of ensuring the residents were being groomed when they received their showers or bed baths. Record review of the facility's policy on Activities of Daily Living (ADL), Supporting, dated December 2001, revealed, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including assistance with hygiene (bathing, dressing, grooming, and oral care).