STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675902	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilot Point Care Center	208 N Prairie St Pilot Point, TX 76258

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #12) of eight residents reviewed for Dignity. The facility failed to treat Resident #12 with dignity and promote enhancement of his quality of life when the resident was not provided a privacy bag for his catheter bag (collects urine from the urinary bladder) on 06/03/2025. This failure could place residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life. Findings included: Record review of Resident #12's Face Sheet, dated 06/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed malignant (conditions that are dangerous to health) neoplasm (abnormal growth of tissue in the body) of the bladder. Record review of Resident #12's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 04/23/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS (screening tool used to assess cognitive status) score of 11. The Comprehensive MDS Assessment indicated the resident had an ostomy (surgical procedure that creates an opening to the body). Record review of Resident #12's Comprehensive Care Plan, dated 03/17/2025, reflected the resident had a urostomy (surgical procedure that creates an opening in the abdominal wall to bypass the urinary bladder) related to bladder CA and one of the interventions was to perform urostomy care. Record review of Resident #12's Physician Order, dated 10/16/2022, reflected Urostomy Care every shift. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/03/2025 at 9:23 AM revealed Resident #12 was in his bed, awake. It was observed that the resident had a catheter bag hanging on the side frame of the bed. The catheter bag did not have a privacy bag and could be seen from the hallway. The resident stated the catheter bag was for his urostomy and he had it since almost three years. He said, if he was not mistaken, his catheter bag did not have a privacy bag since the day prior. He said it would be better if no one would see his urine when the door was open. Observation on 06/03/2025 at 10:26 AM, Resident #12's catheter still does not have a privacy bag and still could be seen from the hallway. In an interview on 06/03/2025 at 10:44 AM, LVN A stated, by right, Resident #12's catheter bag should be inside a privacy bag to avoid embarrassment in case a visitor would come or would pass by. He said he did not notice that the catheter bag was exposed when he did his morning round. He said he would get a privacy and would put the resident's catheter bag inside. In an interview on 06/04/2025 at 6:18 AM, LVN C stated she did not notice that Resident #12's catheter bag was exposed when she did her last round the day prior. She said it should be inside a privacy bag to prevent the resident being humiliated because of his condition. She added that it did not matter if the resident was embarrassed or not, the catheter should be inside a privacy bag. She said it was also her responsibility to put the catheter bag inside the privacy bag. In an interview on 06/05/2025 at 6:19 AM, the ADON stated a catheter bag must have a privacy bag to avoid incidents that could lead to embarrassment. The purpose of the privacy bag was to provide dignity for residents with urinary catheters. The ADON said they have catheter bags that had a leaf on them, and a privacy bag was not needed. But for the kind of catheter bag that Resident #12 was using, it should be inside a privacy bag to prevent exposure of its content. The ADON said the expectation was for the staff to make sure the catheter bags had privacy bags when the residents were inside their rooms or outside their rooms. She said she would continually remind the staff the importance of providing dignity and would coordinate with the DON for an in-service about dignity. In an interview on 06/05/2025 at 7:13 AM, the Administrator stated a catheter bag should be inside a privacy bag to prevent any dignity issue. She said all the staff were responsible in providing dignity to all residents. She said staff must do their due diligence in ensuring the residents had a dignified existence while in the facility. The Administrator said he would coordinate with the DON to monitor that the catheter bags were not exposed. In an interview on 06/05/2025 at 8:09 AM, the DON stated catheter bags should be inside a privacy bag to maintain the resident's dignity. She said the expectation was for all the staff to ensure that the residents were provided dignity, not just providing a privacy bag but also treating them with respect. She said she start an in-service pertaining to providing dignity. Record review of the facility's policy, Dignity 2001 MED-PASS, Inc. revised February 2021 revealed Quality of Life - Dignity & Privacy Operational Policy and Procedure Manual for Long-Term Care revised August 2009 revealed Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or sense of well-being . self-esteem .Policy Interpretation and Implementation . 1. Residents are treated with dignity . at all times . 12. Demeaning practices and standards of care that compromise dignity are prohibited . a. Helping the resident to keep urinary catheter bags covered

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure personal privacy was provided for treatment and confidential records for seven (Resident #3, Resident #17, Resident #27, Resident #29, Resident #43, Resident #54, and Resident #100) of sixteen residents reviewed for Privacy and Confidentiality. 1. The facility failed to ensure LVN B would not check Resident #17's blood sugar and administer her insulin in the hallway on 06/04/2025. 2. The facility failed to ensure LVN A secured Residents #3, #27, #29, #43, #54, and #100's medical information when he left his cart unattended on 06/04/2025. These failures could place the residents at risk of not having their personal privacy maintained during medical treatment and their medical information exposed to unauthorized individuals. Findings included: 1. Record review of Resident #17's Face Sheet, dated 06/04/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #17's Comprehensive MDS Assessment, dated 04/21/2025, reflected the resident had a severe impairment (required significant assistance and support in daily life) in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin in the last seven day. Record review of Resident #17's Care Plan, dated 05/20/2025, reflected the resident had diabetes mellitus and the interventions were to administer medication and check the blood sugar as ordered. Record review of Resident #17's Physician Order, dated 02/13/2025, reflected Insulin Regular Human Injection Solution Pen-injector 100 UNIT/ML (Insulin Regular (Human)) Inject subcutaneously (administer under the skin) with meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/04/2025 at 6:31 AM, LVN B stated he was going to check Resident #17's blood sugar and would administer her insulin afterwards. He prepared his alcohol wipes, a push button lancet, test strip, and a glucometer. He inserted the test strip into the glucometer and then approached the resident, bringing with him the things he prepared. Resident #17 was in her wheelchair in the hallway. He pricked the residents left pointing finger, scooped the blood with the test strip, and said the blood sugar was 179. He said he would be giving the resident 2 units of insulin as per sliding scale. He then prepared the insulin and went back to the resident who was still in the hallway. He pulled the resident's shirt up, exposed the resident's abdomen and injected the insulin on the left lower quadrant of the resident's abdomen. Observation on 06/04/2025 at 6:37 AM revealed the ADON was coming out of her office and saw LVN B administering insulin to Resident #17. She told LVN B that he should have taken the resident back to her room to administer the insulin or went inside the ADON's office, which was approximately six steps away from where the resident was, to do the treatment. In an interview on 06/04/2025 at 6:42 AM, LVN B stated he should have done the treatment inside the Resident #17 room to provide privacy. He said every treatment should be done inside resident's room or somewhere where others would not see the treatment being done for the resident. He said he would not do it again. 2. Record review of Resident #3's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with urinary incontinence (loss of bladder control). Record review of Resident #3's Progress Notes, dated 06/02/2025, reflected Res refused x 2 on final round resident allowed CNA to change linens clothes and brief. Record review of Resident #27's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #27's Blood Sugar, dated 06/04/2025 at 3:37 AM, reflected the value of the resident's blood sugar was 271.0 mg/dL. Record review of Resident #29's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus and schizoaffective disorder (a mood disorder). Record review of Resident #43's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with abnormalities of gait and mobility. Record review of Resident #43's Progress Notes, 05/27/2025, reflected partial report from hospital. Patient will be admitted for fracture (a break in the continuity of the bones) of left humerus (long bone of the upper arm). Record review of Resident #54's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with pain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #54's Physician Order, dated 05/08/2025, reflected Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 1 tablet by mouth three times a day for pain. Record review of Resident #100's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease and neuromuscular dysfunction of the bladder (the normal bladder function is disrupted due to nerve damage). Observation on 06/04/2025 at 7:29 AM revealed a piece of paper was on top of nurse's cart parked in the hallway. The piece of paper indicated that Resident #3 was checked and changed, Resident #27 had diabetes mellitus 1 and with a blood sugar of 271, Resident #29 had diabetes mellitus 2 and was exhibiting restlessness, Resident #43 was on Medicare and had a fracture to the left humerus, Resident #54 refused Norco, and Resident #100 was on oxygen and had a catheter. It was observed that nobody was attending the cart, and the cart was facing the hallway. Several staff and residents were passing by the cart. In an interview on 06/04/2025 at 7:35 AM, LVN A stated he should have made sure that the shift report form was not facing up when he left the cart to administer medication. He said on the shift report form was medical information about the residents and should be confidential. LVN A stated he should have flipped the paper when he left the cart or placed it under his laptop because the information could be exposed and be seen by unauthorized individuals. LVN A said he would be mindful that no information about the residents would be left on top of the cart. In an interview on 06/05/2025 at 6:19 AM, the ADON stated all the care and treatments done for the residents should be completed in the privacy of their rooms. She said she saw LVN B administered the insulin in the hallway and corrected the staff right there and then because it was not proper to administer the insulin in the hallway. She also said that personal and medical information about a resident should be confidential and protected. She said the staff should have secured the paper before leaving the cart unattended. She said the expectations was for the staff be mindful and perform the treatment inside the room and that any information about the residents were not left on top of the cart for everyone to see. She said she would coordinate with the DON too do an in-service pertaining to privacy and confidentiality. In an interview on 06/05/2025 at 7:13 AM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care or treatment to prevent embarrassment and no information was left on top of the cart unsecured. She said the expectation was for the staff to do all the treatment provided inside the room and that no paper with the residents' medical information left on top of the cart. She said she would coordinate with the DON to do an in-service about providing privacy and confidentiality. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2025 at 8:09 AM, the DON stated providing treatment in the hallway was unacceptable. She said being late was not an excuse to check the blood sugar and administer insulin in the hallway. She said he should have ushered the resident to her room or went to the office which is near to where the resident was. She said the residents should be provided privacy at all times. She said the shift report should not had been left unattended with all the medical information about some residents were written. She said it was a HIPPA violation. She said the expectation were that the residents were provided privacy, and that the medical information of the residents were secured. She said she would do an in-service about privacy during and confidentiality of the residents' medical information. Record review of the facility's policy, Dignity 2001 MED-PASS, Inc. revised February 2021 revealed Policy Statement: Each resident shall be cared for in a manner that promotes . self-esteem . Policy Interpretation and Implementation . 10. Staff protect confidential clinical information . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Record review of the facility's policy, Resident Rights 2001 MED-PASS, Inc. revised February 2021 revealed Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation . t. privacy and confidentiality. Record review of the facility's policy, Confidentiality of Information and Personal Privacy 2001 MED - PASS, Inc. revised October 2017 revealed Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy . Policy Interpretation and Implementation . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records . 2. The facility will strive to protect the resident's privacy regarding his or her . b. medical treatment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team for five (Residents #3 #5, #21, #29, and #50) of twelve residents reviewed for Care Plans Revision. The facility failed to complete a quarterly care plan for Residents #3, #5, #21, #29, and #50. This failure could place the residents at risk of care and needs not being met. Findings included: Resident #3 Record review of Resident #3's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #3's Comprehensive Care Plan on 06/04/2025 reflected the last quarterly care plan completed for the resident was on 09/06/2024. Record review of Resident #3's Comprehensive MDS Assessment on 06/04/2025 reflected the last MDS was done on 05/14/2025. Resident #5 Record review of Resident #5's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #5's Comprehensive Care Plan on 06/04/2025 reflected the last quarterly care plan completed for the resident was on 01/12/2025. Record review of Resident #5's Comprehensive MDS Assessment on 06/04/2025 reflected the last MDS was done on 04/15/2025. Resident #21 Record review of Resident #21's Face Sheet, dated 06/04/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #21's Comprehensive Care Plan on 06/04/2025 reflected the last quarterly care plan completed for the resident was on 01/29/2025. Record review of Resident #21's Comprehensive MDS Assessment on 06/04/2025 reflected the last MDS was done on 03/31/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29 Record review of Resident #29's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #29's Comprehensive Care Plan on 06/04/2025 reflected the last quarterly care plan completed for the resident was on 01/22/2025. Record review of Resident #29's Comprehensive MDS Assessment on 06/04/2025 reflected the last MDS was done on 03/26/2025. Resident #50 Record review of Resident #50's Face Sheet, dated 06/04/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #50's Comprehensive Care Plan on 06/04/2025 reflected the last quarterly care plan completed for the resident was on 12/27/2024. Record review of Resident #50's Comprehensive MDS Assessment on 06/04/2025 reflected the last MDS was done on 05/23/2025. Observation and interview on 06/05/2025 at 7:13 AM, the Administrator stated all the residents should be care planned accordingly and timely to make sure all the current care needed by the residents were provided. She said without the care plan, the staff would not know and understand what kind of care to provide. The Administrator checked on Resident #21's care plan and saw that the last care plan done was dated 01/29/2025. She said the DON was the one doing the care plan and she would reach out to her to let her know about the issue. She said the expectation was for all the residents were care planned accordingly and that the care plans were updated quarterly and when needed. She also said she would coordinate with the DON to make sure the care plans were current. Observation and interview on 06/05/2025 at 8:09 AM, the DON stated she was responsible for doing the care plan. She said every resident needed a thorough care plan to ensure the residents received the care proper to their needs. She said the care plan should be in place so the staff providing care would be on the same page. She added, without the care plan, there could be confusion with the care of the residents. She said the care plan should be done quarterly to monitor if there were new interventions or to assess if the goals were not being met. She said the care plan could also be updated if there was a change in condition. She said if the care plan was not updated, as if they were not doing their due diligence in terms of assessing the residents. She turned on her laptop and logged in. She went to Resident #21's profile and saw the date of the last care plan. She did the same for Resident #3, #5, #29, and #50. She said it was an oversight on her side because she was the one responsible in making the care plans. She said she would audit the care plans of the residents and plan to finish the audit in the coming week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2025 at 10:42 AM, the MDS Coordinator stated the care plans were done upon admission and quarterly afterwards. She said the care plans were also updated if there was a change in condition. She said all the care plans should be reflected on the residents' profile so the staff could have access on them. She said after every care conference, the care plan should be placed on the residents' profile. She said she was doing the MDS and the DON was the one doing the care plans. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered 2001 MED - PASS revised March 2022 revealed Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives . to meet the resident's . needs is developed and implemented for each resident . Policy Interpretation and Implementation . 12. The interdisciplinary team reviews and updates the care plan . d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the residents were provided medications and/or biologicals and pharmaceutical services to meet their needs for one (Resident #25) of eight residents reviewed for Pharmaceutical Services. The facility failed to ensure that Resident #25's medications were not left inside the resident's room and that the resident had a physician order for TUMS (antacid used for heartburn and indigestion). These failures could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Review of Resident #25's Face Sheet, dated 06/03/2025, reflected a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with gastro-esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting your mouth and stomach) and schizoaffective disorder (a mental condition characterized by abnormal though processes and unstable mood). Review of Resident #25's Quarterly MDS Assessment, dated 05/12/2025, reflected resident had moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated Resident #25 had gastro-esophageal reflux disease and schizoaffective disorder. Review of Resident #25's Comprehensive Care Plan, dated 04/29/2024, reflected the resident had schizoaffective disorder and one of the interventions were to administer medications and monitor for any side effects. The Comprehensive Care Plan did not indicate that the resident could self-administer his medications. Review of Resident #25's Assessment on 06/03/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage his own medications. Review of Resident #25's Physician Order on 06/03/2025 reflected the resident did not have any order for TUMS. Observation and interview on 06/03/2025 at 9:40 AM revealed Resident #25 was in his bed, awake. It was observed that a small plastic cup with two pills inside was on top of the resident's right side-table. According to the resident, his night nurse left it with him, and the pills were for his heartburn. He said he would take them in a little bit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 06/03/2025 at 10:44 AM, LVN A stated he did not give the Resident #25 anything for heartburn and he did not notice the small cup with pills when he gave the resident his morning medications. He said from the size of the medications, it looks like they were TUMS. He checked the resident's physician order and said the resident did not have an order for TUMS. He said if the resident was taking the medication, there should be an order for it because an order was needed for everything done for the residents. He said the pills should not be left with the resident because the resident might not take them, throw them, or choke while taking them and no one would know. He said he would check if the pills were still inside the resident's room. In an interview on 06/04/2025 6:18 AM, LVN C said that she works from 10 PM to 6 AM the day before. She said the ADON asked her if she gave Resident #25 the pills and she said she did not. She said the only medications that she gave for the resident were his routine medications. She said medications should not be left with the residents to ensure that the resident took them and that if the resident was taking TUMS, there should be an order for it. In an interview on 06/05/2025 at 6:19 AM, the ADON stated medications should not be left with the residents and staff should stay with the resident until the resident was done taking the medications. She said the resident might not take them or someone else might, like another resident or a visitor. She said she asked the night nurse and the night nurse said she did not give Resident #25 anything for heartburn. She said she would coordinate with the DON to do an in-service about not leaving any medications with the residents. In an interview on 06/05/2025 at 7:13 AM, the Administrator stated staff should not leave medications unattended because of the risk of the resident not taking them or the pills not taken on time. She said another risk would be the resident might choke and nobody was there to assist the resident. She said she would coordinate with the DON about the matter and the expectation was no medications would be left with the resident unless the resident had a self-medication assessment. In an interview on 06/05/2025 at 8:09 AM, the DON stated staff should never leave the medications at the bedside for the resident to take later. She said the staff should ensure that the residents took their medications before leaving the room. She said many could go wrong like a resident could hide the pills and take them altogether or the resident might not take them at all. She said the expectation was no medication left inside the room and she would do an in-service pertaining to not leaving the medications with a resident. She also said that she already put the order for TUMS on the Resident #25's profile because every medication administered should have an order. she said she would also do an in-service about physician orders. Record review of the facility's policy, Administering Medications 2001 MED-PASS, Inc. revised April 2019 revealed Policy heading: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so . 4. Medications are administered in accordance with prescriber orders . Record review of the facility's policy, Physician Orders 2001 MED-PASS, Inc. (undated) revealed Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services . Supervision by a Physician . 2. Physicians' orders must be signed electronically or in wet ink and dated.

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	675902	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilot Point Care Center	208 N Prairie St Pilot Point, TX 76258

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored properly in locked compartments for one cart (nurse's cart) of three carts reviewed for Storage of Drugs and Biologicals. The facility failed to ensure that LVN A locked his nurse's cart on 06/04/2025. This failure could place the residents at risk of accessing/opening the cart causing accidental overdose or misuse of medications and not receiving the full benefit of the medication. Findings included: Observation on 06/04/2025 at 1:10 PM revealed a cart was parked in front of the nurses' station. The cart was not locked because the centralized, metal, round lock, located on the upper right corner of the cart, was protruding and the metal lock needed to be pushed to lock the drawers of the cart. The cart was facing the hallway, and the drawers could easily be opened. The drawers of the cart contained various over-the-counter medications, blister packs of medications, and insulins. Several staff and residents were passing by the unlocked cart. LVN A arrived and locked the cart. In an interview on 06/05/2025 at 6:19 AM, the ADON stated the carts should never be left unlocked to prevent unauthorized individuals from gaining access to it. She said residents might be able to open it and take some medications and ingest them or hide them. She said, aside from the residents, staff or visitors could open it and get some medications from it. She said the expectation was for the staff to lock the carts before leaving them. She said she would coordinate with the DON to do an in-service pertaining to locking the cart when left unattended. In an interview on 06/05/2025 at 7:13 AM, the Administrator stated the carts should always be locked so residents, other staff, and visitors could not open them and have access to the medications. She said it could result in accidental ingestion and overdose. she said the expectation was no carts were left unlocked. She said she would coordinate with DON to do an in-service about locking the carts. In an interview on 06/05/2025 at 8:09 AM, the DON stated carts should not be left unlocked, and the drawers facing the hallways. Unauthorized individuals should not be able to open it and gain access to the drawers. She said resident might open it, took some medications, hide it, and took them later. She said the resident might be allergic to the medication or could choke on them. She said even though the staff was called because of an incident, it should be automatic for them to lack the carts before attending to the incident. She said she would do an in-service about the importance of locking the carts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2025 at 8:36 AM, LVN A stated he was not aware that he left his cart unlocked because he was in a hurry due to an incident. He said it was not an excuse because it should be automatic for him to lock the cart. He said the cart should be locked every time it was left unattended because anybody, residents, staff, and visitors, could open it and could get anything from the cart. He said residents could open it and accidentally ingest medications that they were allergic to or choke on some medication. He said he would be mindful next time to always lock the cart every time he would leave his cart. Record review of facility policy Administering Medications 2001 MED-PASS, Inc. revised April 2019 revealed Policy heading: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed . and all outward sides must be inaccessible to residents or others passing by.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. The facility failed to ensure food being served to residents was covered. This failure could place residents at risk for cross contamination and other air-borne illness. Findings included: Observation on 06/05/25 at 12:30 PM of three test trays presented to the Health & Human Services investigators, reflected: Observation of the lunch test tray containing the regular diet, included the dish of food was covered with a cloche (a dome shaped cover used in food service to keep food warm); however, the desert dish containing a slice of cake with frosting was uncovered. Observation of the lunch test tray containing the mechanical soft diet, included the dish of food was covered with a cloche; however, the desert dish containing a slice of cake with frosting was uncovered. Observation on 06/05/25 at 12:02 PM of an opened meal tray cart on the South Hall, reflected: Observation of the trays in the cart contained the dishes of food were covered with cloches and the drinks were covered with saran wrap; however, the desert dishes containing slices of cake with frosting, were uncovered. The cart remained open for approximately two minutes, as C.N.A. D passed trays to residents in their rooms. In an interview on 06/05/25 at 12:18 AM with the Dietary Manager, she stated they cover the foods before sending the trays out, to prevent cross contamination. She stated the deserts were not covered because they didn't have to be, because they were going straight to the cart from the kitchen, so they were not being exposed to possible cross contamination. She stated staff are supposed to keep the carts closed after pulling each tray, to prevent cross contamination. In an interview on 06/05/25 at 12:27 PM with the Administrator and DON, revealed the Administrator stated food is supposed to be covered to prevent anything in the air from getting to the food. The DON agreed with the Administrator's statement. In an interview on 06/05/25 at 1:00 PM with C.N.A. F, she stated food has to be covered to keep the temperature of the food warm and to protect the food from germs and flies. She stated staff are to close the carts after pulling each tray to keep the food warm and to reduce chances of anything getting to the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/25 at 1:18 PM with C.N.A. D, she stated the dishes and drinks are covered in the kitchen and are either immediately delivered to the residents in the dining room or placed immediately on the carts. She stated staff are supposed to keep the cart door closed because it keeps food warm and prevents cross contamination. In an interview on 06/05/25 at 2:30 PM with Dietary Aide G, she stated all food should be covered before leaving the kitchen and while not being closed in the kitchen. She stated it is important to cover the food, to protect it from whatever is in the air. Record Review of the facility's policy on Food Preparation and Service dated November 2022, revealed 4. 'Food Distribution' means the processes involved in getting food to the resident .When meals are assembled in the kitchen and then delivered to residents' rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based 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 #5 and Resident #21) of eight residents reviewed for Infection Control. 1. The facility failed to ensure CNA D would not place Resident #5's catheter bag (collects urine from the urinary bladder) on the floor while transferring the resident on 06/04/2025. 2. The facility failed to ensure CNA D performed hand hygiene while providing incontinent care to Resident #21 and would not put the gloves that she would use for incontinent care inside her pocket on 06/04/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #5's Face Sheet, dated 06/04/2025, reflected the resident was a [AGE] year-old female admitted on the facility on 03/26/2018. The resident was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #5's Comprehensive MDS Assessment, dated 04/15/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (device that drains urine from the urinary bladder). Review of Resident #5's Comprehensive Care Plan, dated 01/12/2025, reflected the resident had an indwelling catheter and one of the interventions was indwelling catheter care every shift. Record review of Resident #5's Physician Order, dated 02/08/2025, reflected Foley cath (catheter) care q shift and PRN. Observation on 06/04/2025 at 7:51 AM revealed CNA D was about to transfer Resident #5 from wheelchair to bed because the resident said she wanted to go back to her bed. It was observed that the resident had a catheter bag hanging at the side of the wheelchair. Before transferring the resident, CNA D placed the catheter bag on the floor and then transferred the resident using the stand and pivot technique. CNA D laid down the resident, pulled the blanket up, and then hung the catheter bag on the railing at the side of the bed. The catheter bag had a privacy bag but when it was on the floor, the catheter bag was outside the privacy bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/2025 at 8:18 AM, CNA D stated she transferred Resident #5 to her bed because the resident wanted to take a nap. She said she should not have placed the catheter bag on the floor because the floor was dirty and whatever was on the floor would transfer to the bag and could possibly travel towards the resident's bladder. She said she was just trying to hurry up and was not aware of outcome of her actions. She said she would be mindful next time she transfer the resident to hang the catheter first before the transfer. 2. Record review of Resident #21's Face Sheet, dated 06/04/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #21's Comprehensive MDS Assessment, dated 03/31/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident was always incontinent for bladder and bowel. Record review of Resident #21's Quarterly Care Plan, dated 01/29/2025, reflected the resident had bowel and bladder incontinence and one of the interventions was to provide pericare (cleaning the private parts of an individual) after each incontinent episode. Observation on 06/04/2025 at 1:45 PM revealed CNA D and CNA E were about to provide incontinent care to Resident #21. Both CNAs sanitized their hands and put on a pair of gloves. CNA E went to right side of the resident while CNA D went to left side. CNA D placed a brief on the resident's side table, pulled the resident's hospital gown up, unfastened the brief, and pushed it between the resident's thighs. She pulled some wipes and cleaned the resident's perineal area (area between the thighs) using the front to back technique. She did it five times. After cleaning the perineal area, she instructed the resident to roll towards the right side. Both CNA's assisted the resident to turn. CNA D started to clean the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief and threw it on the trash can. After throwing the soiled brief, she pulled a pair of gloves from her pocket, and put them on. She did not sanitize her hands before putting on a new pair of gloves that she pulled from her pocket. She took the brief from the side table, placed it under the resident, and fixed it. Both CNAs assisted the resident to roll back and fastened the brief on both sides. After fixing the brief, both CNAs washed their hands. In an interview on 06/04/2025 at 1:59 PM, CNA D stated hand hygiene was important to prevent cross contamination and to prevent infection. She said she did hand hygiene before and after Resident #21's incontinent care and did change her gloves after cleaning the resident's bottom. She said when she changed her gloves, she did not sanitize her hands before putting on a new pair of gloves. She said she should have taken the box of gloves at bedside instead of placing some into her pocket to make sure that the gloves that she would be using were clean because her pocket might be dirty. She said she would be mindful the next time she does incontinent care to do hand hygiene in between changing of gloves and not to put the gloves inside her pocket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2025 at 6:19 AM, the ADON stated the catheter bag should not be placed on the floor because the floor was dirty. She said the staff should have hung it first before transferring the resident instead of placing it on the floor. She said she would check Resident #21's catheter if it needed to be changed. She said the catheter should be off the floor to prevent cross contamination and possible infection. She said staff must sanitize their hands before putting on a new pair of gloves and not put their gloves on their pockets for the same reason. She said she would coordinate with the DON to do an in-service about not placing the catheter on the floor, hand hygiene, and infection control. In an interview on 06/05/2025 at 7:13 AM, the Administrator stated catheter should be off the floor, hands should be sanitized in between changing of gloves, and gloves should not be placed inside the pockets to prevent spread of germs and development of infection. She said the staff should always make sure that they were aware that their actions could cause harm to the residents. She said she would coordinate with the DON to do an in-service about infection control. In an interview on 06/05/2025 at 8:09 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection and included in hand hygiene was sanitizing the hands before putting on a pair of gloves. She said gloves should not be placed on the staff's pockets because there was no assurance that their pockets were clean. She said, basically, the gloves from the pockets were deemed dirty. She said catheter bags should not be placed on the floor because the floor was dirty. She said not sanitizing the hands before donning a pair of gloves, putting gloves on the pocket, and putting the catheter bag on the floor could cause probable infections. she said the expectation was for the staff to be mindful with what they were doing to protect the residents from infection. She said she would do an in-service pertaining to infection control focusing on hand hygiene, no gloves on the pockets, and not placing the catheter bag on the floor. she said she was responsible in training the staff pertaining to infection control. Record review of the facility's policy, Catheter Care, Urinary 2001 MED-PASS, Inc. updated July 2024 revealed Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control . 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . b. Be sure the catheter tubing and drainage bag are kept off the floor. Record review of the facility's policy, Perineal Care 2001 MED-PASS, Inc. (undated) revealed Purpose: The purpose of this procedure is to provide cleanliness . to prevent infections . Steps in the Procedure . 4. Discard soiled gloves, sanitize hands. Re-glove prior to touching clean linens/adult brief. Record review of the facility's policy, Handwashing-Hand Hygiene Policy and Procedures 2001 MED-PASS, Inc. (undated) revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections . Policy Interpretation and Implementation . Indications for Hand Hygiene . c. after contact with blood, body fluids, or contaminated surfaces, d. after touching a resident, e. after touching the resident's environment, f. before moving from work on a soiled body site to a clean body site on the same resident, g. immediately after glove removal.