STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675913	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points of Pflugerville	521 S Heatherwilde Blvd Pflugerville, TX 78660

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the maintenance for comfortable sound levels for 4 of 8 residents (Resident #40, Resident #52, Resident #62, Resident #67) reviewed for homelike environment.The facility failed to ensure that Resident #40, Resident #52, Resident #62, and Resident #67 resided in an environment free from excessive noise levels. This failure placed residents at risk for becoming agitated and disturbed. Findings included: A record review of Resident #40's face sheet dated 3/23/2025 reflected a [AGE] year-old male readmitted on [DATE] with diagnoses of Alzheimer's disease (neurological condition), hyperlipidemia (high cholesterol), hypertension (high blood pressure), type 2 diabetes (uncontrolled blood sugar), dementia (neurological condition), heart disease and peripheral vascular disease (decreased circulation).A record review of Resident #40's MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated severely impaired cognition.A record review of Resident #40's care plan last reviewed on 3/11/2026 reflected that discharge from the facility was not feasible as evidenced by impaired cognition related to Alzheimer's dementia. Interventions included, respect resident's right to view nursing facility as his/her home.A record review of Resident #62's face sheet dated 5/14/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of Parkinson's disease (neurological disorder), type 2 diabetes (uncontrolled blood sugar), heart failure, age-related debility, and mixed hyperlipidemia (high cholesterol).A record review of Resident #62's MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. A record review of Resident #62's care plan last reviewed on 3/11/2026 reflected that he had impaired cognitive function or impaired thought processes. Interventions included that staff were to provide the resident with a homelike environment.A record review of Resident #67's face sheet dated 5/14/2026 reflected a [AGE] year-old female readmitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung disease), major depressive disorder (depression), hypothyroidism (underactive thyroid), type 2 diabetes (uncontrolled blood sugar), hyperlipidemia (high cholesterol), bipolar disorder (mental disorder), and insomnia (inability to sleep).A record review of Resident #67's MDS assessment dated [DATE] reflected a BIMS score of 11, which indicated moderately impaired cognition.A record review of Resident #67's care plan last reviewed on 3/03/2026 reflected that discharge from the facility was not feasible. Interventions included that staff were to respect the resident's right to view the nursing home as her home.During an interview on 5/12/2026 at 2:30 PM, Resident #52 stated that a very loud buzzing sound went off when staff did not shut the door in 400-hall properly. Resident #52 stated the noise woke him up sometimes. An observation of the 400-hall on 5/13/2026 at 10:42 AM revealed a door alarm was sounding loudly.During an observation and interview on 5/13/2026 at 10:42 AM, CNA H stated that when exiting the door, you have to make sure it's really closed. CNA H stated that if the door was not closed all the way, the alarm would go off. Observed a doorway in 400-hall that led to a small hallway with an exterior door. CNA H demonstrated how the door did not shut completely if allowed to shut on its own. Observed force was required to close the door so that it latched shut completely.An observation on 5/13/2026 at 10:59 AM revealed the SW walked into the 400-hall from (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outside. The alarm then started sounding off loudly.During an interview and observation on 5/13/2026 at 11:01 AM, CNA I stated that when the door was opened, it had a problem. Observed the alarm went off again. Observed that the door was already latched, however, the door alarm sounded off anyway. Observed CNA I type in a code to stop the alarm from sounding. An observation on 5/13/2026 at 11:05 AM revealed the door alarm on 400-hall was sounding off loudly. Observed the exterior door to be ajar. During an observation and interview on 5/13/2026 at 11:06 AM, revealed the door alarm on the 400-hall was observed sounding off. FM O stated, Whoever it was didn't close the door. and said that was why the alarm was sounding off.During an observation and interview on 5/14/2026 at 10:37 AM, Resident #40 was observed lying in bed. Resident #40 stated the noise when the alarm sounded off bothered him. During an observation and interview on 5/14/2026 at 10:40 AM, Resident #52 was observed sitting in his wheelchair. Resident #52 stated that the door alarm woke him up every night. Resident #52 stated that he had complained to staff about the noise, but the aides just told him there was a sign on the door that reminded staff to shut the door completely.During an observation and interview on 5/14/2026 at 10:48 AM, Resident #67 was observed sitting in her room. Resident #67 stated the alarm had been going off since she had been there and it bothered her but she had not complained to staff because they always turned it off eventually. Resident #67 stated it sometimes woke her up.During an observation and interview on 5/14/2026 at 10:51 AM, Resident #62 was observed lying in bed. Resident #62 stated it does bother him when the alarm in the 400-hall sounded off. During an interview translated by an HHSC translator on 5/14/2026 at 12:14 PM, the Maintenance Director stated that he was aware of the alarm that sounded in the 400-hall and you have to pull it shut. The Maintenance Director stated that an air bubble between the two doors caused a suction and he added a part about two months ago to help it shut. The Maintenance Director stated he added that part due to a resident complaints. The Maintenance Director stated that he put a sign on the door to remind staff to pull the door shut after using it and that it was happening a lot less now.During an interview on 5/14/2026 at 12:44 PM, the DON stated there was no policy on homelike environment. The DON stated, We try as much as possible to make sure everything is quiet. The DON stated she had heard the alarm sounding off on the 400-hall but she did not know what caused it to sound. The DON stated she did not think it was related to the door latching shut. The DON stated a loud sound could make residents scared or startled. During an interview on 5/14/2026 at 2:30 PM, LVN C stated yes that residents had complained about the alarm on 400-hall. LVN C stated that Resident #67 and Resident #52 had complained to him about the sound and, if you don't close the door enough, it sounds off. LVN C stated that after the alarm sounded off, he needed to wait 10 seconds. LVN C stated, If you just open it and walk through, it's not going to close. LVN C stated he had brought it up with the Maintenance Director, but he told him that he could not do anything. LVN C stated, It would bother me, too.During an interview on 5/14/2026 at 4:55 PM, the Administrator stated, We try to keep it as homelike as possible. The Administrator stated that volume levels varied throughout the facility, but we try to keep it a level where we're not disturbing them as much as possible. The Administrator stated that he was aware that the alarm on the 400-hall bothered residents, and that was why a sign was posted by the door reminding staff to pull it shut. The Administrator stated that staff were in-served on the door alarm, and that he would try to find it. The Administrator stated that the alarm could interrupt residents' rest or agitate them.A record review of the facility's undated policy titled Resident Rights reflected the following: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) for 3 of 14 residents (Resident #8, Resident #35 and Resident #61) to meet the needs of the resident, in that:The facility failed to administer Resident # 8's pain medication on time for 34 administrations. The facility failed to administer Resident #35's Parkinson's medication on time as schedule for 34 administrations. The facility failed to ensure LVN E did not document Resident #61's medications in the MAR as being administered before resident took his medications.These failures placed Residents at risk for uncontrolled pain, tremors, decrease quality of life and hospitalization.3. Record review of Resident# 61's undated admission face sheet reflected a 68-year male was who was admitted to the facility on [DATE]. His diagnoses included epilepsy unspecified not intractable without status epilepticus (seizure disorder that is recurrent but generally controlled or responsive to treatment, without prolonged medical emergencies), hypothyroidism unspecified (underactive thyroid), benign prostatic hyperplasia (BPH) without lower urinary tract symptoms (enlarged prostate gland that is not pressing on the urethra or bladder to cause urination issues), Alzheimer's disease with early onset (a rare form of dementia affecting people under 65). Record review of Resident #61's comprehensive MDS assessment dated [DATE] reflected BIMS score of 05 indicating severe cognitive impairment. The MDS reflected Resident #25 had a seizure disorder or epilepsy. Record review of Resident # 61's care plan reflected: The resident has Seizure Disorder-Date Initiated: 02/22/2026. Goal included- The resident will remain free from injury related to seizure activity through review date -Date Initiated: 02/22/2026. Revised on: 03/09/2026. Interventions included- Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. He had a care plan Initiated: 02/22/2026 indicating The resident has potential fluid deficit r/t poor intake and impaired cognition A goal included The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor.- Initiated: 02/22/2026 and revised on: 03/09/2026. Interventions included- Administer medications as ordered. Monitor/document for side effects and effectiveness.Encourage Fluids during med pass and with each care intervention. He had a care plan Initiated: 02/22/2026 indicating The resident has impaired cognitive function/dementia or impaired thought processes Goal included- The resident will maintain current level of cognitive function through the review date.-Date Initiated: 02/22/2026. Intervention included- Administer meds as ordered -Date Initiated: 02/22/2026. The resident has an anticonvulsant ordered r/t for pain and seizures.-Date Initiated: 03/09/2026. Goal included- The resident will not experience any adverse effects from the medication.-Date Initiated: 03/09/2026. Intervention included-Give medications as ordered. Monitor/document for effectiveness and side effects.Inform the physician for any adverse effects and behavioral symptom increase/changes.- Date Initiated: 03/09/2026 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of^Resident #61's^order^summary report^reflected:^ -Alfuzosin HCl ER Tablet Extended Release 24 Hour 10 MG. Give 1 tablet by mouth one time a day for benign prostatic hyperplasia. Start date: 02/20/2026 -Finasteride Oral Tablet 5 MG (Finasteride) Give 1 tablet by mouth one time a day for BPH. Start date: 02/21/202 - Sertraline HCl Oral Tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth one time a day related to depression, unspecified. Start date: 02/21/2026 - Gabapentin Oral Tablet 400 MG (Gabapentin). Give 2tablet by mouth two times a day for Neuropathic pain. Start date: 02/19/2026 - Levetiracetam Oral Tablet 1000 MG (Levetiracetam). Give 1.5 tablet by mouth two times a day for Seizures. Start date: 02/20/2026 An observation of the medications administration on 05/15/2026 approximately at 7:56 a.m. revealed LVN E prepared Resident #61's five medications one by one and placing them into a medication cup. Approximately at 7:59 a.m., LVN E documented that all five medications were given in Resident 61's MAR. Further observation revealed LVN E sanitized her hands after closing the laptop's screen and locking the med cart. She went to the resident's room with the medications and Resident #61 took his medications approximately at 8:02 a.m. LVN E sanitized her hands after she left the resident #61's room and moved the medication cart to the next door. In an interview on 5/13/2026 at 2:00 p.m. with LVN E, she stated that she has been working in the facility for about one month. She stated that there are five rights of administering medications: right patient, right drug, right time, right dose, and right route. She stated that she should not chart Resident #61's five medications as given before he took them because he could refuse to take all these medications or some of them. She stated that she would not be able to uncharted them in the MAR as not given or refused, and she would not be able to document the reason for not giving his medications or the reason for refusal. LVN E stated that the resident's physician must be notified about any refused medications and depending on the medication, the physician then would decide if the medication orders needed to be changed or if new orders needed to be given. In an interview on 05/13/2026 at 4:40 p.m. with the DON, she stated she has been working in the facility for 5 years. She stated that before administering medications, the nurse must verify 5 rights of administering medications: right resident, right medication, right reason, right dose, right time. DON stated the last thing after administering the medications is to document it by checking the medications in the resident's MAR. She stated documenting the medications in the MAR, as given before resident takes them, is not acceptable because resident can refuse medications, but it is already charted as given. In an interview on 05/14/2026 at 7:24 a.m. with ADON, she stated she had been working in the facility for 10 years. She stated that there are seven rights of administering medications: right patient, right medication, right time, right dose, right route, right frequency, right documentation. She stated it is expected that nurses and med aides document the medications that are administered in MAR after residents take their medications. She stated that it is a med error if the medication is signed off in the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR as given before it is administered to a resident. She stated that any not given or refused medications must be reported to the physician along with the reason for not giving the medication or the reason for the refusal so the physician can evaluate and modify the medication treatment regimen if needed. In an interview on 05/14/2026 at 5:26 p.m. with ADM, he stated medications could not be clicked in MAR as administered because residents can refuse medications. Record review of a document provided by the facility titled Medication Administration and General Guidelines dated 2025 reflected: Adheres to the 6 Rights of Medication Administration: 1) Right Dose 2) Right Route 3) Right Resident 4) Right Medication 5) Right Time 6) Right Documentation Observes the resident take the medications Documents the administration of each medication on the MAR & Controlled Medications on the Control Sheet The findings included: Findings included: 1.Review of Resident #8's face sheet dated 05/15/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis unspecified (a chronic, autoimmune disease of the central nervous system. The immune system mistakenly attacks myelin—the protective sheath covering nerve fiber disrupting electrical signals between the brain and the body), , Muscle Wasting and Atrophy, and Muscle Weakness. Review of Resident #8's quarterly MDS assessment dated [DATE] reflected a BIMS score of 05 indicating severe cognitive impairment. Section J-Health Conditions reflected Resident #8 received scheduled and PRN pain medication, pain was always present and Resident #8 frequently experienced pain. Section J also reflected Resident #8's pain frequently interfered with therapy and day-to-day activities with numeric rating of 6 on the scale 0-10 with 10 being the highest pain. Review of Resident #8's care plan revised 10/09/2025 reflected the following: *Resident #8 had Multiple Sclerosis with interventions to give medications as ordered, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor/document for side effects and effectiveness Pain management as needed, See MD orders. Provide alternative comfort measures PRN. Resident #8 was on pain medication r/t Multipe Sclerosis(a chronic autoimmune disease of the central nervous system) ith intervention to administer medication as ordered. Review of Resident #8's physician order reflected: Pregabalin Oral Capsule 50 MG (Pregabalin) Give 1 capsule by mouth three times a day for PAIN start date 10/01/2025. Review of Resident #8's MAR for the months of April and MAY 2026 reflected: Pregabalin Oral Capsule 50 MG (Pregabalin) Give 1 capsule by mouth three times a day for PAIN scheduled at 07:00 am, 1:00 pm and 07:00 pm Review of Resident #8's medication administration audits reflected Resident 8's pain medications were given at the following times: Scheduled 07:00 am doses were administered at: *04/01/26 at 09:40 am *04/06/26 at 09:12 am *04/11/26 at 08:39 am *04/17/26 at 11:35 am *05/12/26 at 11:09 am Scheduled 07:00 pm doses were administered at: *04/01/26 at 09:05 pm *04/02/26 at 09:06 pm *04/04/26 at 08:19 pm *04/06/26 at 9:39 pm *04/07/26 at 8:38 pm *04/08/26 at 8:59 pm *04/09/26 at 9:24 pm *04/10/26 at 9:57 pm (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*04/11/26 at 9:28 pm *04/12/26 at 9:53 pm *04/13/26 at 9:23 pm *04/14/26 at 8:05 pm *04/16/26 at 10:35 pm *04/17/26 at 10:07 pm *04/18/26 at 9:26 pm *04/19/26 at 9:20 pm *04/20/26 at 8:23 pm *04/21/26 at 9:42 pm *04/22/26 at 9:48 pm *04/25/26 at 8:10 pm *04/26/26 at 8:08 pm *04/27/26 at 9:48 pm *04/29/26 at 9:28 pm *05/04/26 at 9:19 pm *05/06/26 at 9:57 pm *05/07/26 at 8:06 pm *05/08/26 at 9:49 pm *05/09/26 at 9:12 pm *05/12/26 at 10:31 pm During an interview on 05/14/2026 at 3:09 PM with Resident #8 she said she was not getting her pain medications on time. She said getting her pain medications late affected her physically because she was in pain. Resident #8 said that getting her medications late affected her emotionally because she cried because she was in pain from not getting her medications. During an interview on 05/15/2026 at 11:26 AM the NP said Resident #8's had pain because she had Multiple Sclerosis (a chronic, unpredictable autoimmune disease of the central nervous system (brain, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spinal cord, and optic nerves). The NP said Resident #8 did not have very good use of her legs and because Resident #8 stayed in bed a lot she had pain in her bilateral lower extremities (both legs and feet simultaneously). The NP said Resident #8 had chronic pain and Resident's scheduled pain medications should be administered timely. The NP said Resident #8 did not tell her she was not getting her pain medications on time. The NP said if Resident #8 received two dose of her scheduled pain medication close together it would not hurt her but she would be a little sleepier. 2.Review of Resident #35's face sheet date 05/15/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of Parkinson's Disease without dyskinesia without mention of fluctuations (Parkinson's is a progressive neurological disorder that primarily affects movement. It occurs when brain cells that produce dopamine—the chemical responsible for coordinating smooth, purposeful muscle control—die or stop working. Dyskinesia is a category of movement disorders characterized by involuntary, erratic, and uncontrollable muscle movements). Review of Resident #35's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 indicating no cognitive impairment. Review of Resident #35's care plan revised 04/13/2026 reflected Resident #35 had Parkinson with interventions to give medications as ordered by the physician. Monitor/document side effects and effectiveness, Monitor/document ability to perform ADLS. Report any improvement or decline to MD, Monitor/document/report to MD PRN s/sx of Parkinsons complications: Poor balance, Constipation, Poor coordination, Insomnia, Dysphagia, Tremors, Gait disturbance, Incontinence, Muscle cramps or rigidity, Decline in range of motion Skin Review of Resident #35's physician orders reflected: Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 2 tablet by mouth three times a day for Parkinson's disease dated 11/28/2025. Review of Resident #35's MAR for the months of April and MAY 2026 reflected: Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 2 tablet by mouth three times a day for Parkinson's disease scheduled at 07:00 am, 1:00 pm and 07:00 pm Review of Resident #35's medication administration audits reflected Resident 8's pain medications were given late, more than an hour pass the schedule times on the following dates: Scheduled 07:00 am doses were administered at: *04/11/2026 given at 08:04 am *04/29/2026 given at 09:24 am *05/12/2026 given at 09:50 am Scheduled 7:00 pm doses were administered at: * 04/02/2026 at 09:01 pm (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*05/05/2026 at 08:13 pm *05/06/2026 at 09:51 pm *05/09/2026 at 9:13 pm *05/11/2026 at 8:39 pm *05/12/2026 at 10:25 pm During an interview on 05/14/2026 at 3:15 PM with Resident #35 she said her tremors from her Parkinson's got bad if she did not get her Parkinson's medication as scheduled. She said when she had tremors, it wore her out physically. Resident #35 said emotionally it made her upset because she knew her tremors would be worse. Resident #35 said she was on everyone else's schedule when getting her medications. During an interview on 05/14/2026 at 2:29 PM with RN A she said when she passed medications the scheduled time frame to give medications was one hour before the medication was scheduled and one hour after the medication was scheduled. RN A said if the medication was given after one hour the time the medication was scheduled, it was a medication error. During an interview on 05/14/2026 at 3:22 PM with LVN S she said they have an hour window before and an hour window after the time medication was scheduled to administer the medication to the resident. LVN S said she could not give medication after an hour it was scheduled to be given, because it would be too late and she would have to contact the provider. LVN S said it would be a medication error if she provided medication too late and did not let the provider know. LVN S said she knew Resident #35 and had given her medications at night. She said Resident #35 did not refuse medication and Resident #35 had never told LVN S she wanted her medication later. During an interview on 05/14/2026 at 3:30 PM with the NP she said medications had a time frame to be administered - one hour before the medication was scheduled and one hour after the medication was scheduled. The NP said if Resident #35 was not getting her Parkinson's medication as scheduled it could cause Resident #35 to have more tremors and dyskinesia (a category of movement disorders characterized by involuntary, erratic, and uncontrollable muscle movements). The NP said it was better that Resident #35 got her Parkinson's medication on a routine schedule. The NP said it was better for her to receive the Parkinson's medication spaced out and not too close together. She said if a resident missed a scheduled dose of medication or received a scheduled medication very late the nursing staff should notify the NP. The NP said if residents requested their medication to be given at a different time than prescribed, she would want to be notified so she could make a change to the dosing time. The NP said if there was a problem and the nurses were unable to issue medication on time the facility was supposed to notify the provider medications were administered late. The NP said she would think that contacting her when medications were administered late would be protocol. The NP said in the last two weeks she had not had any notifications that residents' medications were administered late. The NP said it was a valid concern that Resident #35 was not getting her Parkinson's medication on time. During an interview on 05/14/2026 at 3:50 PM the DON said if there was an assigned time to give a medication, there was a window of one hour before the medication was scheduled and one hour after the medication was scheduled to administer the medication. The DON said that scheduled medications (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675913	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points of Pflugerville	521 S Heatherwilde Blvd Pflugerville, TX 78660

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not administered late every single day. She said medications might be administered late if a staff member was running late. She said she was aware that on 04/29/2026 a lot of scheduled medications were administered late. The DON said it was a hectic day and everyone on the floor tried to catch up to administer the medications on time. She said she knew it was a problem. The DON said no residents had a negative outcome from the late medication administration. The DON said staff checked on the residents to make sure the residents were okay. She said she did not document in the residents' progress notes that residents received late medications and did not document that residents were monitored for any adverse effects. The DON said she walked around and checked on residents and asked the staff to check on the residents. The DON did not remember if she called the MD or the NP to tell them that a lot of residents received scheduled medications late on 04/29/2026. The DON said she apologized to a couple of residents who said they did not get their medications on time. The DON said if a resident was refusing to take medication from the MA should let the nurse know. The DON said staff were supposed to call her if a resident did not want to take their medication. The DON said if they were successful in administering the medication two or three hours later, the nurse could enter a progress note stating that the resident received the medication late. The DON said Resident #35's Parkinson's medication should be given on time. The DON said if it was not given on time, Resident #35 could have more tremors. The DON said she did not remember if she called the MD or the NP to tell them medications were administered late on 04/29/2026. The DON said it was policy to call the MD or the NP if residents received their scheduled medications late. During an interview on 05/14/2026 5:30 pm with the ADM he said he was not aware that on 04/29/2026 a lot of residents received their medications late. The ADM said it was his expectation that when scheduled medications were administered two hours late, the MD or NP should be notified. His expectation was for them to monitor the residents and contact the physician. The DON said that if Parkinson's medication were administered late residents with a diagnosis of Parkinson's could have increased tremors. The ADM said increased tremors would affect resident therapy because the resident could not function if the resident was shaking. The ADM said not taking the Parkinson's medication could affect the resident psychosocially because residents might not want to be around other people if it was out of the norm for them to have tremors. He said residents wanted to feel like themselves as long as they could and not want to shake. The ADM said all late medications from 04/29/2026 should have been documented, the late medications reported to the MD or NP, and residents monitored. During an interview on 05/14/2026 at 6:15 PM the PTA said she was Resident #35's physical therapist. The PTA said Resident #35 had not told her that she had not received her Parkinson's medications on time. The PTA said if residents with a diagnosis of Parkinson's did not get their medications on time it could affect their tremors, could make them more unstable, and possibly make them confused. The PTA said Resident #35 was not confused. The PTA said there was a relationship between taking Parkinson's medications on time and improvement in therapy. She said taking the Parkinson's medication could help with symptoms and when a resident wanted to do a task, they might initiate the task faster. The PTA said it was pretty important to take the Parkinson's medication on time. During an interview on 05/15/2026 12:32 PM with the DON she said the facility had a liberalized time for medications that meant there was a bigger window to administer the medications. The DON said Sinemet (a brand-name prescription medication used primarily to treat Parkinson's disease) should not be liberalized. The DON said the MD controlled the liberalized timing. The DON said in nursing, if you give the same medication 30 minutes apart that was double dosing. The DON said nursing judgment was not to give medications at the same time. She said if some medications were given too (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available in LinkRx (pharmacy management software) otherwise authorized personnel should refer to Drug Reference material provided by facility. Procedure- 10. Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise). Before or after meal orders are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. 12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized than the caregiver administering the medication will enter the correct documentation that will then be electronically date/time stamped with their initials. Checklist for completing proper steps in the administration of medications . Adheres to the 6 Rights of Medication Administration: 1) Right Dose 2) Right Route 3) Right Resident 4) Right Medication 5) Right Time 6) Right Documentation Documents the administration of each medication on the MAR & Controlled Medications on the Control Sheet

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure storage of medications used in the facility were in accordance with currently accepted professional principles and included the appropriate expiration dates to preserve their integrity for the stored medications, and to store medications properly to prevent deterioration for one medications (400-hall Nurse and Medication aide cart) carts out of four reviewed for medications storage for three (Resident #s 57, #62 and # 100) of 8 residents review in that:1. The facility failed to ensure an expired OTC medication belonging to Resident #57 was removed from the 400-hall nurse's cart after it was opened and used.2. The facility failed to label Resident #62's insulin pen with the opened date after it was opened and being used on the 400-hall nurse's cart.3. The facility failed to discard Resident # 100 's insulin pen after it had been opened for 14 days passed the recommended discard day on the 400-hall nurse's cart.These failures could place residents at risk for missed medications and/or not receiving the therapeutic effect of medications.Findings included:1. Review of Resident #57's face sheet date 05/13/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Heart failure unspecified (occurs when the heart muscle doesn't pump blood as effectively as it should), Chronic Atrial Fibrillation (a sustained, long-term irregular heart rhythm where the top chambers (atria) quiver instead of beating effectively), Essential (Primary) Hypertension (high blood pressure with no identifiable medical cause).Review of Resident #57's admission MDS assessment dated [DATE] reflected a BIMS score of 14 indicating intact cognition. Review of Resident #57's care plan initiated 04/14/2026 reflected Resident #57 was at risk for adverse medication effect and for behavior monitoring, potential/actual impairment to skin integrity, an ADL Self Care Performance Deficit r/t activity intolerance, limited mobility, and pain.Review of Resident #57's physician order reflected:Magnesium Oxide Oral Tablet 400 MG (Magnesium Oxide) Give 1 tablet by mouth two times a day for ANTACIDS, MINERALS &ELECTROLYTES With meals dated 4/13/2026Review of Resident #57's MAR for the month of April 2026 reflected Resident #57 was administered Magnesium Oxide Oral Tablet 400 MG (Magnesium Oxide) Give 1 tablet by mouth two times a day for ANTACIDS, MINERALS & ELECTROLYTES With meals from 04/14/2026 to 04/30/2026Review of Resident #57's MAR for the month of May 2026 reflected Resident #57 was administered Magnesium Oxide Oral Tablet 400 MG (Magnesium Oxide) Give 1 tablet by mouth two times a day for ANTACIDS, MINERALS & ELECTROLYTES With meals from 05/01/2026 to 05/12/20262. Review of Resident #62's face sheet date 05/13/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with other Circulatory complications (damage in large and small blood vessels caused by chronic hyperglycemia) .Review of Resident #62's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Review of Resident #62's care plan initiated 02/16/2026 reflected Resident #62 had Diabetes Mellitus, was at risk for adverse medication effects, and on behavior monitoring. Resident #62 had an ADL Self Care Performance DeficitReview of Resident #62's physician order reflected:NovoLOG Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale:if 0 - 150 = 0 unit;151 - 200 = 2 units ;201 - 250 = 3 units;251 - 300 = 4units;301 - 350 = 5 units;351 - 400 = 6 units BS >400 Give 6 units and notify hospice, subcutaneously before meals and at bedtime for diabetesDated 02/18/2026 Review of Resident #57's MAR for the months of April and May 2026 reflected Resident #62 was administered Novolog insulin almost every day. 3. Review of Resident #100's face sheet date 05/13/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus without complication (indicates high blood sugar due to insulin resistance or insufficient insulin (continued on next page)

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	675913	A. Building B. Wing	05/15/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	production, but without systemic damage to the eyes, nerves, kidneys, or circulatory system), repeated falls, need for assistance with personal care. Review of Resident #100's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. MDS also reflected Resident #100 had Diabetes Mellitus. Review of Resident #100's care plan initiated 05/12/2026 reflected Resident # 100 required enhance barrier precautions and was full code.Review of Resident #100's physician order reflected:Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro)Inject as per sliding scale:if 71 - 149 = no insulin;150 - 199 = 1 unit ;200 - 249 = 2 unit;250 - 299 = 3 units ;300 - 349 = 4 units;350 - 399 = 5 units,subcutaneously before meals and at bedtime for DM2 Greater then 399 give 6 units and notify provider. Dated 05/11/2026During an observation and interview on 05/13/2026 at 8:28 am with LVN E, while reviewing the 400-hall medication cart, it was observed Resident #57 had a bottle of Magnesium 400mg extra strength with an expiration date of November 2025. It was also observed Resident #62 had an insulin pen of Novolog 100 unit/ML without opened date. It was again observed that Resident #100 had insulin Lispro 100 unit/ML pen with opened date of 03/31/2026 with sticker indicating discard 28 days after opening. LVN E stated the potency of medication would decrease when the medication expired. LVN E stated they (the nurses) were not supposed to have expired medication on the medication cart, and all of the nurses were responsible for removing expired medications from the medication cart. LVN E stated when an insulin was opened, the nurse who opened the insulin was responsible for putting the opened date on the pen to know how long it had been used to be thrown out.During an interview on 05/13/2026 at 9:10 am, the ADON stated the charge nurses were responsible for taking out the medications from the cart when they expired. The ADON stated they were not supposed to take expired medications. The ADON stated Resident #57 brought the magnesium 400mg from home when he was admitted to the facility about 2 weeks ago, and he stated he was taking it at home. The ADON stated the nurses were supposed to check the magnesium when Resident #57 brought it. The ADON stated insulins should be dated when opened, and they were good for about 20 days when they were opened. The ADON stated Resident #100 came with her insulin pen from home when she was admitted to the facility, the nurses needed to give her insulin, and the pharmacy had not yet sent Resident #100's insulin. The ADON stated insulins needed to be dated to follow the potency of the medication. The ADON stated Resident #100 should have started a new insulin pen because the opened date of 3/31/2026 was passed the date.During an interview on 05/14/2026 at 12:27 pm, the DON stated expired medication should be taken off the medication cart as soon as possible. The DON stated it was not ok for residents to take expired medication, and she did not know if the potency or the effectiveness of an expired medication would stay the same or decrease because she was not a pharmacist. The DON stated the nurses working on the medication carts were responsible for removing expired medications from the medication carts. The DON stated she audited the mediation carts week before and she did not see the medications and the undated insulin pens on the cart. The DON stated short acting insulins were good for 28 days when they were opened and long-acting insulins were good for about 27 days. The DON stated that the pharmacy recommended to discard insulins after 28 days. The DON later stated because insulins were liquids, when expired, it decreased the potency of the medication, 4 units would work as if it were 3 units.Review of Insulin Storage Guideline, undated, presented by the facility reflected: Lispro-Humalog, Admelog-Expiration date after opening or removing from the refrigerator -28 daysAspart---Novolog--- Expiration date after opening or removing from the refrigerator -28 days.Review of facility's policy titled Medication Storage in the Facility dated 2025 reflected: PolicyMedications and biologicals are stored safely, securely, and properly following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exits.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the menu for three of three days reviewed for menu adherence. The facility failed to serve the lunch menu as planned on 5/12/2026 and on 5/13/2026.CK M failed to use a large enough scoop for oatmeal during breakfast on 5/14/2026 and failed to serve orange juice to Resident #95.These failures placed residents at risk for decreased intake, weight loss, and nutritional inadequacy.Findings included:A record review of the facility's menu for 5/12/2026 reflected the following items were to be served for lunch: pork shank with teriyaki glaze, steamed rice, pacific blend vegetables, egg roll, watermelon wedge, and iced tea. During an interview on 5/12/2026 at 10:53 AM, DS K stated that what was on the menu that day was not ordered, so she had to substitute everything. DS K stated, everything was missing. DS K stated that CK L was a cook in the facility and CK L had been placing the orders. DS K stated that they used to have a substitution log, but they had not had one in the last few weeks since the Dietary Manager had been gone. DS K stated that he had been out since April 14th (2026).An observation of meal service on 5/12/2026 at 11:50 AM revealed that beans, rice, and enchiladas were being served for lunch. There were no vegetables, egg roll, or watermelon. A record review of Resident #95's meal ticket dated 5/13/2026 reflected that she was to receive 4 ounces of orange juice.An observation on 5/13/2026 at 8:07 AM revealed that Resident #95 did not have orange juice on her breakfast tray. During an interview on 5/13/2026 at 11:59 AM, CK L stated that the Dietary Manager had been out for three weeks. CK L said that he took inventory, sent it to the Dietary Manager, and the Dietary placed food orders. CK L said if they were out of a menu item, he went to the Administrator to see if we can go get it or we'll substitute. CK L stated that he did keep a log of items that were substituted. A record review of the facility's menu for 5/13/2026 reflected the following items were to be served for lunch: chicken fajitas, charro beans, guacamole & lettuce salad, warm tortilla, picante sauce, apple enchiladas. An observation of a sample meal tray on 5/13/2026 at 12:43 PM revealed lunch consisted of one taco on a flour tortilla, chickpeas, and a salad with lettuce, tomato and cheese. There was no picante sauce, guacamole or apple enchilada.During an interview on 5/14/2026 at 9:59 AM, CK M stated that they did not have pinto beans for the charro beans the day prior (5/13/2026). CK M stated they had a substitution log, but it did not tell the cooks what to use in place of the missing item. CK M stated that he did not fill out the substitution log the day prior (5/13/2026). CK M stated that CK L was the acting manager and he told him to use garbanzo beans (chickpeas). CK M said they were out of pinto beans and guacamole on 5/13/2026. CK M stated I was just trained how to cook when asked what kind of training he had received on portion sizes. When asked how he know which scoop to use for which dish, CK M stated, The guide tells the color and the size. CK M stated, Puree has the same scoops every time and the main meal has the same scoops every time. CK M stated that the Dietary Supervisor had trained him on that. CK M stated that for the oatmeal that morning, he had used the beige (ivory) scoop. CK M stated that they had orange juice and if a resident did not receive it that morning, we messed up. A record review of the facility's menu for 5/14/2026 reflected that a half cup serving of hot cereal was to be served for breakfast. During an observation and interview on 5/14/2026 at 10:51 AM, Resident #62 was observed lying in bed. Resident #62 stated that he liked the oatmeal but, I wish they were larger because I get hungry sometimes. Resident #62 clarified that he wished the portion sizes were larger. During an observation and interview on 5/14/2026 at 10:40 AM, Resident #52 was observed sitting in his wheelchair. Resident #52 stated he received a quarter cup of oatmeal that morning and it was not enough. Resident #52 stated he was not happy with the garbanzo bean substitution for charro beans the day prior (5/13/2026). Resident #52 stated that he was sometimes still hungry after meals. During an interview on 5/14/2026 at 11:46 AM, Resident #95 stated that she would love to have orange juice and she guesses it's because they're out that she did (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not receive it. Resident #95 stated that the beans served the day prior (5/13/2026) were hard and they weren't the right beans because they were not charro beans. Resident #95 stated she did not receive guacamole the day prior (5/13/2026) as noted on her meal ticket. Resident #95 stated We're all adults and we need more food than what we're given. Resident #95 said yeah, she did not feel she received enough to eat. Resident #95 stated she had complained to staff about not receiving orange juice. Resident #95 stated that the food was either too hard, too cold, undercooked, overcooked, or not enough and I'm still hungry. Resident #95 said it's not what's on the ticket.An observation of the kitchen on 5/14/2026 at 12:04 PM revealed the ivory scoop was 2/5 of a cup.During an interview on 5/14/2026 at 11:10 AM, the RD stated that portion sizes were written on recipes and substitutions should be written on the substitution log for the RD to review at their next visit. She said, It has to be an equivalent. When asked how not following the menu could impact residents, the RD stated residents could get more carbohydrates, it could be a problem with diabetes, and it could be insufficient nutrition.During an interview on 5/14/2026 at 12:44 PM, the DON stated the dietitian monitored the kitchen to ensure they served the correct portion sizes. The DON stated that the dietitian visited the facility twice a month. The DON stated that the Administrator was covering for the Dietary Manager since he was out on medical leave. The DON stated that she had noticed some issues with portion sizes in the last few months, and so she talked with the dietitian. The DON stated that the dietitian went and checked the scoop sizes last month. When asked how the incorrect serving sizes could affect residents, the DON stated, They might have weight loss.During an interview on 5/14/2026 at 4:55 PM, the Administrator stated that the facility had set [NAME], and if something needed to be substituted, we have a substitution log. The Administrator stated that he was not sure whether the substation log had been completed recently. The Administrator stated that the Dietary Manager had been out for a little over a month and he was the acting manager. The Administrator stated that the Regional Dietary Manager came in about three weeks ago and said that everything was good with the scoop sizes. When asked how residents could be impacted if they received less food than the menu called for, the Administrator stated there was potential for weight loss.A request was made for policies on menu substitutions, following menus, and portion sizes on 5/14/2026 at 9:23 AM but were not provided prior to exit.

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	675913	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points of Pflugerville	521 S Heatherwilde Blvd Pflugerville, TX 78660

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive and at a safe and appetizing temperature for residents who consumed foods orally from the only kitchen in the facility in that: The facility failed to provide palatable food that was attractive or appetizing to residents' who complained the food did not look or taste good and that it was frequently cold from 1 of 1 kitchen.The test tray of the lunch meal on 05/13/2026 was lukewarm, unappetizing in appearance (no condiments provided, and no beans observed in charro beans) the chicken fajita tasted heavily salted, and the tray lacked meal items described on the menu without a substitution (guacamole 5/13/26). These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life.The findings include: Resident #52Review of Resident #52's face sheet dated 05/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels) and major depressive disorder. Review of Resident 52's quarterly MDS assessment dated [DATE] reflected a BIMS score of 10 indicating moderate cognitive impairment. Review of Resident 52's diet order dated 12/11/25 reflected a regular texture, regular consistency diet. During an interview on 05/12/26 at 02:30 PM with Resident #52 he stated that he had meal concerns because it was always the same thing he complained the food was cold and the oatmeal was too runny. He stated he has expressed his concerns to staff at the facility specifically concerning the cold food. He stated the facility had not done anything to improve the cold meals because they were still cold. Resident #49Review of Resident 49's face sheet dated 05/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included sepsis (reaction to an infection that causes immune system to harm healthy tissue and organs) and type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels). Review of Resident 49's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident 49's diet order dated 03/20/26 reflected a mechanical soft texture, regular consistency for diet. During an interview on 05/14/26 at 08:10 AM Resident #49 stated his issue was with the breakfast oatmeal frequently being too watery. During a confidential group interview on 05/13/26 at 02:30 PM, 10 of 14 confidential residents described the following concerns:* Breakfast is cold and it's the same thing every morning.* listed (meal ticket) condiments are not there (on the tray) and the dessert does not match what the ticket says they stated this bothered them because they frequently do not know what they are going to be eating.* The food is too salty and sometimes no seasoning at all. The residents stated that their concerns have been given to the SW related to the food palatability. Residents also stated they do not receive enough food, they stated they will sometimes get seconds and other times they wont. Resident #37Review of Resident #37's face sheet dated 05/17/26 reflected an [AGE] year-old female admitted on [DATE] with diagnosis that included type 2 diabetes (metabolic disorder when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin) with diabetic chronic kidney disease, anemia (deficiency in healthy red blood cells or hemoglobin), and gout (form of arthritis characterized by sudden sever pain, swelling, and tenderness in one or more joints). Review of Resident #37's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7 indicating moderate cognitive impairment. Review of Resident #37's diet order dated 07/23/25 reflected she was on a regular texture, regular consistency diet, fortified food with breakfast, lunch, and dinner related to protein calorie malnutrition. During an interview and observation on 05/14/26 at 10:46 AM with Resident #37, she stated she had the chicken fajita taco meal served on 05/13/26. She stated that the meat was salty and she had to mix the salad with it and make it less salty to consume the meal. She stated she was not provided with condiments and did not have dressing or salsa for her taco. Resident #37 also (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complained that the meal was not sufficient, she stated one taco was not enough for a meal and that it did not fill her up. She stated she was not provided with an apple enchilada but was given a cookie that she said she did not eat and pointed to a cookie on her bedside table that she still had. Resident #37 described the iced tea as terrible and said, it was not sugary and no sugar was provided. Resident #37 stated that she has made multiple complaints to staff about the food but they go unheard and unresolved because there are ongoing dietary issues. She stated she has also started to avoid breakfast because she would be provided with cornflakes (cereal) but not enough milk, she described the food as being consistently not enough. Resident #95Review of Resident #95's face sheet dated 05/17/26 reflected a [AGE] year-old female admitted on [DATE] with diagnosis that included type 2 diabetes mellitus (metabolic disorder when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin) with diabetic neuropathy (nerve damage), anemia (deficiency in healthy red blood cells or hemoglobin), and hypertension (high blood pressure). Review of Resident #95's admission MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #95's diet order dated 03/23/26 reflected she was on a regular texture, regular consistency, reduced concentrated sweets. During an interview on 05/14/26 at 11:46 AM with Resident #95, she stated she had the fajita taco meal served on 05/13/26. She stated she did not like the charro beans and added, they were hard; they weren't the right kind of beans, they weren't charro beans. She stated the potion was not enough and she had to ask for seconds, we're all adults and we need more food than we are given she felt she never had enough to eat. Resident #95 stated her meal did not include the guacamole that he meal ticket and menu stated she would get. Resident #95 wanted to add that the palatability of the food was often an issue and said, the food is too hard, too cold, undercooked, overcooked, or not enough to eat and I'm still hungry- it's a joke and its not what is on the ticket. Review of the kitchen menu for 05/13/26 reflected the following was to be served:3oz chicken fajitas, 1/2 cup of charro beans, 1/2 cup of guacamole and lettuce salad, 1 warm tortilla, 2 tablespoons of picante sauce, 1 apple enchilada, and 8 fl oz of ices tea. An observation on 05/13/26 at 12:50 PM of the meal test tray the following items were observed on the tray: A cup of iced water, a cup of iced tea, one single soft taco (flour tortilla) with chicken fajita (no toppings observed), a side salad which consisted of a mixture of lettuce, white cheese, and tomatoes (no guacamole observed as stated on the menu; no substitution provided), a small bowl of charro beans (which were observed made with garbanzo beans), and on the side a cookie. Based on the initial observation the meal was not appealing as the plate lacked toppings and various items such as condiments like the picante sauce listed on the menu, no salad dressing, the guacamole which was not provided, no salt or pepper, no sugar for the tea, and there was no apple enchilada. The temperature of the tortilla was cold and the chicken fajita was lukewarm; the tray was not placed on the meal cart as instructed to dietary staff by surveyors and instead came straight from the kitchen when requested. The observation of this meal tray was prepared immediately upon obtaining the tray directly from the kitchen which still reflected cold to lukewarm unappetizing temperatures The charro beans were tasted and had an odd flavor as the wrong beans were used to create the dish; the beans used for the charro beans were chickpeas which have a more [NAME] and slightly dry or grainy flavor. The tea was pleasant and tasted like a typical unsweet tea; however, no sugar was provided to sweeten it as desired. The cookie was sweet and pleasant; it was soft in the center and not an unpleasant substitution for the apple enchilada not observed on the tray. During an interview and observation on 05/14/26 at 01:55 PM with CK M he stated it was the expectation from dietary that the food served to the residents was cooked well, not spoiled or old, and that all residents enjoyed what they were eating. CK M stated that he did not personally know of any of the grievances the residents had because that was not communicated to him by management or the facility and he has not seen any grievances on paper. CK M stated he had cooked the meal provided 05/13/26 with the chicken fajita taco but stated he did not taste it to check its quality. He stated he had not tasted the food he made here and provided to the residents, he stated that in the past the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chefs have told him to try the food before its served but he said it was not something he did. CK M stated condiments are not available outside of the kitchen on the dining room tables or the stations in the dining room for other staff to pass out and that residents rely on the dietary staff while preparing the meal trays to place the condiments on the tray before it goes out (an observation made at this time reflected no salt pepper shakers at the tables or at the stations in the main dining room). CK M stated he was not aware of any potential negative outcome to unpalatable food, he stated if a resident was not happy with their meal they are able to request something else through nursing staff who would relay the massage to him and he would be able to provide something from the always available menu of alternatives. During an interview on 05/14/26 at 02:09 PM with the SW she stated she was the grievance official for the facility. She stated she gets grievances about the food here all the time and said it's the biggest grievance residents have. She stated the specific complaints made about the food services was related to portion size and said some residents for example will say I only got 5 fries, the taste they say they don't like it - they will say they don't like the food texture, or complain that the food is always cold. She stated she does come out to look at the trays during meal services and will assist with passing out meal trays on the hall her office was located at. She said during those times her observations of the meal trays were that they rarely had condiments which was one of the residents grievances no condiments, not seeing ketchup with fries etc The SW state she has brought these resident concerns to the dietary manager (DM) multiple times but had not escalated the concern to the Administrator. She stated it had not been escalated because she figured the DM would be able to handle those concerns. She stated that if residents were not happy with their meals that they could request a substitution, however, if they were consistently unhappy about the meals they received it had the potential to result in weight loss for the residents. During an interview on 05/14/26 at 04:42 PM with the Administrator he stated he was also the current acting Dietary Manager due to the Dietary Manager being on leave for approximately the last month. He stated it was his expectation that the food taste good saying, it should start with your eyes, should look good and taste good. The Administrator stated he had not received any recent grievances concerning food quality or taste. The Administrator stated he has tasted the facility food but could not say exactly when the last time he tried the food. He stated he had seen condiments being provided. He stated the meal on 05/13/26 that he was not aware the chickpeas were substituted for pinto beans in the charro beans made; he stated that was not a good substitution. The Administrator stated that a potential negative outcome to residents not enjoying the food and eating had the potential to result in weight loss adding, you have to eat to survive. At this time the Administrator stated again there was no policy on food palatability. Record review was completed of facility grievances for the last 12 months (date range) which reflected the following recent grievances:A grievance dated 11/05/25 reflected a dietary concern reported to the SW, resident complained the kitchen still not giving condiments with meals. Resident stated she gets frustrated when she cannot get the appropriate condiments with her meals. Resident stated the kitchen had addressed this in the past but she had not received anything but ketchup in a small container occasionally.A grievance dated 02/17/26 reflected a dietary concern reported to the SW, resident complained that she does not like the food.A grievance dated 04/06/26 reflected a dietary concern reported to the SW, resident complained about food not being edible. Resident stated the meat was very hard and she already has issues with chewing. Record review of Resident Council minutes (confidential resident meeting) for the last 12 months (date range) reflected the following recent dates with food concerns reported:*01/13/26- are meals at a satisfactory temperature reflected no*02/10/26- are meals at a satisfactory temperature reflected no*04/07/26- are meals at a satisfactory temperature reflected no*05/11/26- are meals at a satisfactory temperature reflected no often additional resident comments under meal service concerns reflected, doesn't appeal; no milk, no coffee, no sugar/creamer The facility food palatability policy was requested on 05/13/26 at 04:22 PM; the facility stated there was no policy related to food palatability available.

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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, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchens reviewed for sanitation.The facility failed to ensure all food items were dated with an open date on 5/14/2026.The facility failed to ensure all food items were properly covered, labeled and dated on 5/12/2026 and on 5/14/2026.CK N failed to ensure that the temperature of fried chicken was checked before serving lunch on 5/12/2026. CK N failed to ensure that the pureed enchiladas were at least 135ˆ when serving lunch on 5/12/2026.The facility failed to ensure that the thermometer was sanitized between testing each food item. These failures placed resides at risk for foodborne illness.Findings included: An observation of the kitchen's dry storage room on 5/12/2026 at 10:03 AM revealed a container filled with a white granular substance that was open to air. The container was not labeled or dated. An observation of the kitchen on 5/12/2026 at 11:07 AM revealed there was an undated container filled with dried, circular, loop-shaped cereal without a label.During an observation and interview on 5/12/2026 at 11:44 AM, CK N was observed taking food temperatures on the service line. CK N stated no that she had not been documenting the temperatures because the Dietary Manager had been out and he was the one who printed the logs. CK N stated that she thought the food on the service line needed to be at 165 ˆ. Observed CK N measure the temperature of the beans, rice, pureed rice, pureed vegetables, and pureed enchiladas. CK N used a paper towel to wipe the thermometer in between food items and she did not sanitize the probe. Observed that the temperature of the pureed enchiladas was 130ˆ and the item was not removed from the service line.An observation of the dry storage room on 5/12/2026 at 11:57 AM revealed the storage bin with the white granular substance was still open. The bin was not in use.An observation of the service line on 5/12/2026 at 11:58 PM revealed there was fried chicken on the serving line that was not there before. The temperature of this item was not checked.During an interview on 5/12/2026 at 12:09 PM, CK N stated no she did not measure the temperature of the fried chicken before serving it. CK N then checked it, and it was 161ˆ. CK N stated I guess that the Dietary Manger trained her on service line temperatures. CK N stated that she used to work as a line cook, she started working in the facility in September of 2025, and it's completely different here. stated that she did not know the difference between cooking temperatures and serving temperatures. During an interview on 5/14/2026 at 9:59 AM, CK M stated that he thought CK L trained him on taking temperature and yes the thermometer should be sanitized in between temping each food item. CK M stated that whoever opened a container should write the date it was opened on it.During an interview on 5/14/2026 at 10:14 AM, CK M stated he did not know why the bins in the dry storage were not labeled but said they should be. CK M stated that they contained rice, cornmeal, and sugar.An observation on 5/14/2026 at 10:14 AM revealed a sign posted in the dry room storage that reflected, please date and label everything in pantry.An observation of the kitchen on 5/14/2026 at 10:16 AM revealed there was an opened container of sweet & sour sauce dated 12/10/2025 and an opened container of roasted salsa verde dated 3/25/2026. During an interview on 5/14/2026 at 10:16 AM, CK M stated that the dates on the sweet & sour sauce and salsa verde were received dates and not opened dates. During an interview on 5/14/2026 at 11:10 AM, the RD stated that the expectation was that staff labeled items with an open date and stored them in a sealed container. The RD stated she believed the facility's policy was 140ˆ for serving temperatures and that staff needed to sanitize the thermometer between each food item. When asked how failing to label or date items could affect residents, the RD stated they could be fed something they're allergic to or it could cause illness if they ate something that had gone bad. The RD stated that contamination of the thermometer could occur if it were not sanitized.During an interview on 5/14/2026 at 4:55 PM, the Administrator stated that staff should check food temperatures before serving and that minimum serving temperature needed to be 135ˆ. The Administrator stated that all items needed a received (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date, an open date and a use-by date. The Administrator stated that it could cause foodborne illness if sanitation polices were not followed.A record review of the facility's policy titled Food Storage and Supplies dated 2012 reflected the following: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects.Dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. record review of the TAC chapter 553 reflected the following: ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (D) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature and for a time specified underSS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57 C (135 F) or above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 3 of 3 residents (Resident #2, Resident #3, Resident #74) reviewed for infection prevention.1. The facility failed to ensure Treatment Nurse labeled Resident #74's wound dressing on 05/12/2026.2. The facility failed to ensure CNA J properly performed perineal care for Resident #2 with foley catheter on 05/12/2026.3. The facility failed to ensure Resident #2's catheter drainage bag was positioned correctly and not laying on the floor on 05/13/2026.4. The facility failed to ensure RN A disinfected the blood pressure cuff before and after obtaining Resident # 3's BP reading during medication administration on 05/13/2026. These failures could place residents at risk for cross contamination and the spread of infection.The findings included: 1. Record review of Resident #74's quarterly MDS dated [DATE] reflected no BIMS score due to MDS not yet being completed. MDS addressed Resident #74's diagnoses as listed above. Resident #74's cognitive skills for daily decision-making assessment reflected: Severely impaired - never/rarely made decisionsRecord review of Resident #74's undated face sheet reflected a 65-year female was admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations (refers to the early or stable phases of the disease where patients maintain predictable symptom control without involuntary movements or off/on medication swings), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline that impacts daily life, but lacks co-occurring behavioral, psychiatric, or mood issues), unspecified abnormalities of gait and mobility (walking or movement difficulties e.g., shuffling, limping, imbalance where the precise underlying cause is not yet identified or documented), need for assistance with personal care (need for help with activities of daily living).Record review of Resident #74's undated care plan reflected: The resident has a stage 3 pressure ulcer Left ischium (the lower and back part of the hip bone). -Date Initiated: 11/18/2025. Goal included- The resident's Pressure ulcer will show signs of healing and remain free from infection through review date. -Date Initiated: 11/18/2025. Interventions included- Notify nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care.-Date Initiated: 11/18/2025.Resident #74 has a potential for pressure ulcer development r/t decreased mobility, incontinence.-Date Initiated: 11/25/2024. Goal included- will have intact skin, free of redness, blisters or discoloration through review date.-Date Initiated: 11/25/2024.Interventions included- Needs assistance to turn/reposition as needed/requested. - Date Initiated: 11/25/2024. Follow facility policies/protocols for the prevention/treatment of skin breakdown.-Date Initiated: 11/25/2024. Incontinent care after each episode and apply moisture barrier. -Date Initiated: 11/25/2024. Inform the resident/family/caregivers of any new area of skin breakdown.-Date Initiated: 11/25/2024. Notify nurse immediately of any new areas of skin breakdown: Open area,Redness, Blisters, Bruises, discoloration noted during bath or daily care.-Date Initiated: 11/25/2024. Weekly skin check by licensed nurse. Notify MD if skin breakdown occurs- Date Initiated: 12/02/2024. Resident is on enhanced barrier precautions.-Date Initiated: 10/14/2025. Goal included- There will not be anytransmission of infection from or to the resident.-Date Initiated: 10/14/2025. Interventions included- Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity- Date Initiated: 10/14/2025. Perform hand sanitation before entering the room and prior to leaving the room.-Date Initiated: 10/14/2025. Posting at the resident's room entrance indicating the resident is on enhanced barrier precautions.-Date Initiated: 10/14/2025 has Parkinson's -Date Initiated: 12/07/2024 Goal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included- will remain free of further s/sx, discomfort or complications related to Parkinson's disease through review date. -Date Initiated: 11/20/2025. Interventions included- Give medications as ordered by the physician. Monitor/document side effects and effectiveness.-Date Initiated: 12/07/2024. Monitor/document/report to MD PRN any s/sx of aspiration or dysphagia: choking, fever, coughing. Refer to ST for any dysphagia problems.-Date Initiated: 12/07/2024. Monitor/document/report to MD PRN s/sx of Parkinsons complications: Poor balance, constipation, poor coordination, insomnia, dysphagia, tremors, gait disturbance, incontinence, muscle cramps or rigidity, decline in ROM, skin breakdown, mood changes, decline in cognitive function.-Date Initiated: 12/07/2024.Record review of^Resident #74's^order^summary report^reflected:-Skin tear to Left knee: Cleanse wound with wound cleanser/NS, pat dry, apply 2% mupirocin to wound bed, cover with dry dressing. As needed for wound healing: Start date: 04/30/2026.-Skin tear to Left knee: Cleanse wound with wound cleanser/NS, pat dry, apply mupirocin 2% to woundbed, cover with dry dressing. one time a day for wound healing: Start date: 05/01/2026.-Stage 4 pressure wound on left ischium (lower, posterior bone of the pelvis): clean with wound cleanser/NS, pat dry, skin prep peri wound, apply collagen and calcium alginate (highly absorptive, non-woven wound dressings made from brown seaweed) with silver to wound bed, cover with super absorbent gelling dressing as needed for wound healing: Start date: 05/13/2026.-Stage 4 pressure wound on left ischium: clean with wound cleanser/NS, pat dry, skin prep peri wound, apply collagen and Calcium alginate (highly absorptive, non-woven wound dressings made from brown seaweed) with silver to wound bed, cover with super absorbent gelling dressing one time a day for wound healing: Start date: 05/13/2026.-Wound and Skin Healing Support. Route: Intravenous (IV). Infusion Bag: 250 mL Normal Saline (0.9% NaCl) minimum volume. Administration: Slow IV Drip. Rate: Infuse at 250 mL/hour until complete. one time only for wound healing for 7 days IV Additives to be mixed in fluid bag: Vitamin C 5g, B Complex 1ml, Zinc10mg, Biotin 5mg, Magnesium Chloride 1g, Aminoblend 5ml.-Start date: 05/20/2026-Decubi-Vite Oral Capsule (Multiple Vitamins with minerals) Give 1 capsule by mouth one time a day for wound healing.Start date: 10/16/2025.During an observation of Resident #74's wound care on 05/12/2026 approximately at 1:50 p.m. revealed the Treatment nurse removed Resident #74's wound dressing from her left ischium which was not dated and initialed, had a brown spot approximately 3 cm in diameter. No foul odor was noted. Treatment nurse provided wound care to resident's ischium area and applied a new dressing; Treatment nurse did not put the date, time and her initials on the new dressing. Further observation approximately at 2:00 p.m. revealed the Treatment nurse removed Resident #74's wound dressing from resident's left knee; the wound dressing had no date and initials. Treatment nurse provided wound care to resident's left knee area and applied a new dressing; she did not put the date, time and her initials on the new dressing. 2. Record review of Resident #2's face sheet, dated 05/14/26, reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Her diagnoses included acute chronic systolic congestive heart failure (longstanding weak heart muscle experiences a sudden, severe worsening of symptoms), obstructive and reflux uropathy, unspecified refers to a condition where (urine flow is blocked and/or abnormally flows backward toward the kidneys, causing back-pressure and kidney swelling), need help with personal care (need assistance with activities of daily living such as such as bathing, dressing, eating, mobility, and toileting), type 2 diabetes mellitus without complications (a condition where the body does not use insulin properly, leading to high blood sugar), chronic kidney disease, unspecified (long-term kidney damage or reduced function lasting over 3 months that has not been staged (1-5) or specifically diagnosed by a provider regarding its underlying cause).Record review of Resident #2's quarterly MDS dated [DATE] reflected BIMS score of 13 indicating the resident was cognitively intact. Resident #2's assessment reflected she has indwelling catheter, including suprapubic catheter and nephrostomy tube. Resident #2 needs Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.Record review of Resident #2's care plan reflected: Resident is on enhanced barrier precautions.-Date Initiated: 05/01/2026.Goal included- There will not (continued on next page)

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	675913	A. Building B. Wing	05/15/2026

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Five Points of Pflugerville	521 S Heatherwilde Blvd Pflugerville, TX 78660

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be any transmission of infection from or to the resident.-Date Initiated: 05/01/2026.Interventions included- Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity- Date Initiated: 05/01/2026. Perform hand sanitation before entering the room and prior to leaving the room.-Date Initiated: 05/01/2026. Posting at the resident's room entrance indicating the resident is on enhanced barrier precautions.-Date Initiated: 05/01/2026. Resident #2 has bladder and bowel incontinence. -Date Initiated: 12/31/2025.Goal included- Resident #2 will remain free from skin breakdown due to incontinence and brief use through the review date. -Date Initiated: 12/31/2025. ' Resident #2 is risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. -Date Initiated: 12/31/2025.Interventions included- Incontinent care at least q2h and apply moisture barrier after each incontinent episode. - Date Initiated: 12/31/2025. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.-Date Initiated: 12/31/2025. Report to charge nurse any foul-smelling urine or if the urine is any color other than yellow.-Date Initiated:12/31/2025.Record review of^Resident #2's^order^summary report^reflected:- Monitor foley catheter Q shift for leakage, blockage, sediment buildup, or low output every shift. -Start date: 04/30/2026- Urine output every shift. -Start date: 04/30/2026-Lactulose Oral Solution 10 GM/15ML (Lactulose). Give 15 ml by mouth three times a day for CKD (chronic kidney disease unspecified)-Start date: 05/01/2026.An observation of peri care on 05/12/2026 at 2:15 p.m. revealed CNA J wiped over Resident #2's left side of labia majora by using one wipe going from top to bottom; not separating the labia majora. CNA J performed the same peri care technique on the right side of resident's labia majora; one wipe going from top to bottom and not separating the labia majora. Further observation revealed CNA J moved to clean the foley catheter by holding the catheter approximately 1.5 inches below the urinary meatus and wiping the catheter downward. CNA J lowered Resident #2's bed after completely providing peri care and left Resident # 2's Foley bag touching the floor.An observation on 05/13/2026 at 8:21 a.m. revealed Resident #2's catheter drainage bag was lying on the left side of Resident #2's bed. 3. Review of Resident #3's face sheet, dated 05/13/26, reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anoxic brain damage, not elsewhere classified (non-traumatic brain injury from oxygen loss), dysphagia following other cerebrovascular disease (swallowing impairment caused by vascular brain injuries other than acute stroke, such as chronic ischemic disease or vascular dementia), tracheostomy status (indicates that a patient has an opening in their windpipe (trachea) to assist with breathing or clear airway blockages), gastrostomy status (clinical condition of having a surgically created opening (stoma) into the stomach).Review of Resident #3's quarterly MDS assessment dated [DATE], reflected no BIMS due to MDS not yet being completed. MDS addressed Resident #3's. Resident #3's cognitive skills for daily decision-making assessment reflected: Severely impaired - never/rarely made decisions. Resident #3's MDS assessment reflected no speech- absence of spoken words. Dependent - Helper did all the effort. Resident did none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.Review of Resident #3's care plan reflected:Resident #3 has impaired cognitive function r/t anoxic brain injury.-Date Initiated: 12/22/2024. Goal included. - Resident #3 will have needs adequately met through the review date.-Date Initiated: 12/31/2025. Intervention included- Monitor/document /report to MD any changes in cognitive function, specifically changes in level of consciousness, mental status.-Date Initiated: 12/22/2024 requires tube feeding r/t dysphagia, anoxic brain injury-Date Initiated: 06/15/2024. Goal included. - insertion site will be free of s/sx of infection through the review date.-Date Initiated: 06/15/2024. Resident #3 will be free of aspiration (inhaling foreign materials into the airway or lungs) through the review date. -Date Initiated: 06/15/2024. Interventions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included: Check placement prior to feeding and medication administration.-Date Initiated: 06/29/2024. Check residual before medications and feedings; return contents after each check.-Date Initiated: 06/29/2024. Resident #3 has Oxygen Therapy r/t chronic respiratory failure, tracheostomy status.-Date Initiated: 06/15/2024. Goal included- will have no s/sx of poor oxygen absorption through the review date.-Date Initiated: 06/15/2024. Intervention included- May use oxygen at 2-5 l/m via trach mask to keep saturation level above 92% every shift for hypoxia (low oxygen in the blood).-Date Initiated: 06/29/2024.Record review ofˆResident #3'sˆorderˆsummary reportˆreflected:ˆ-Assess before &after a treatment - O2 Sat, Resp. Rate, Pulse, Breath sounds (Key-0=Clear, 1=Wheezing, 2=Pleural rub, 3=Rales, 4= Stridor 5=Other breath sounds (if other document in Progress Note). Total time in minutes to assist with tx and assessments two times a day for SOB related to chronic respiratory failure with hypoxia. Start date: 07/01/2025.-Check O2 sat Q shift and PRN as needed. Start date: 02/14/2025.-Check O2 sat Q shift and PRN every shift for preventative. Start date: 02/14/2025.- Lisinopril Oral Tablet 5 MG (Lisinopril) Give 1 tablet via PEG-Tube one time a day for hypertension.related to hypertensive heart disease without heart failure. Start date: 02/15/2025.During an observation of medication administration on 05/17/2026 approximately at 7:08 a.m. revealed RN A came out of the room # 209 holding a blood pressure cuff in her hands and placed the blood pressure cuff on the top of the nurses' cart that was at the door. RN A sanitized her hands and moved the nurses' cart next door. RN A picked up the BP cuff from the nurses' cart after sanitizing her hands went to Resident #3's room. Resident #3's signage noted, outside of his door, resident was on EBP. RN A applied the BP cuff on Resident #3's left ancle and obtained his BP reading. RN A placed the BP cuff inside of the nurses' cart. RN A satanized her hands and proceeded to prepare Resident #3's medications. RN A pulled the BP cuff out of the nurses' cart and disinfected it after documenting Resident #3's given medications in MAR. RN A failed to disinfect a reusable blood pressure cuff between residents.In an interview on 05/13/2026 at 8:37 a.m. with CNA J, she stated she had been working in the facility for about 2 years. She could not recall when she had her last training on providing peri care to residents with foley catheters. CNA J stated that she had infection control in-service training last week, the training did cover hand hygiene, using PPEs when providing care to the residents in EBP rooms. She stated she usually did not provide peri care to the residents with foley catheters since she always worked in the secure care unit, and there are no residents with foley catheters. She stated that she was asked to provide a peri care with foley bag in a different unit yesterday.In an interview on 05/13/2026 at 9:17 a.m. with the Treatment Nurse, she stated she was not aware that the facility requires to label the wound dressing by writing the date and initials on the resident's wound dressing because using a sharpie on the resident's dressing might be an infection control issue. She stated she will confirm this with her supervisor. Treatment nurse stated that not labeling the wound dressing potentially could cause a wound infection because it would not be clear when and who changed the resident's wound dressing the last time. She stated that resident's foley bag must be placed below the resident's bladder, but it should not be laying on the floor because the resident can get a UTI.In an interview on 05/13/2026 at 11:33 a.m. with RN A, she stated that she did not sanitize the BP cuff before and after obtaining Resident #3's BP and placed the BP cuff inside of the nurses' cart. She stated that the blood pressure cuffs should be sanitized between every resident-use to prevent the spread of infections. RN A stated the foley bag must be placed inside of the privacy bag and kept below the resident's bladder. She stated that the Foley bag could be hung on the resident's bed rails but it can't be left laying on the floor because it was an infection control issue.In an interview on 05/13/2026 at 4:47 p.m. with the DON, she stated that the proper peri care provided for a resident with foley bag was going from clean to dirty from top to bottom using one wipe and throwing it after each swipe. She stated that the labia must be left untouched in the middle because of the insertion of the catheter at meatus. DON stated that the catheter must be held 2 inches below the insertion site, and the catheter must be cleaned going downward. DON stated if the foley bag that was inside of the privacy bag touched floor, it might be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because the bed was lowered too low. DON stated she had not seen the residents' Foley bags laying on the floor, but if it is on the floor, it must be a resident threw the Foley bag on the floor. DON stated that she needed to confirm with the corporate if residents' wound dressings should be labeled with date and time. She stated that staff wanted to make sure that residents were comfortable and writing with a sharpie on the wound dressing applied on the resident's wound might make residents uncomfortable. She stated that the facility might start applying a piece of a brown tape with the date, time and initials on the wound dressing, but she was not sure if it would stay there. She stated that the Treatment nurse applied a brown tape on the Resident #74's wound dressing later. She stated that it was important to know when and who has changed the wound dressings so wound care is not skipped. DON stated that regular wound dressing changes were important, so a wound was healing and not getting infected. She stated that staff were expected to sanitize BP cuffs before and after using it to obtain a residents' blood pressure reading.In an interview on 05/14/2026 at 7:24 a.m. with ADON, she stated that she had been working there for 10 years. She was also an infection preventionist. She stated she was providing infection control in-service training weekly. She stated the trainings cover hand hygiene protocol: Staff must wash hands before and after providing direct care for residents and to sanitize hands before and after going to residents' rooms. She stated that Foley bags must be inside of the privacy bag and not touching a floor. She stated she did not understand the rationale for this, but the policy was stating it. She stated that she did not think that sanitizing BP cuffs before and after using it to obtain residents' BP can affect infection control. She stated that it did not affect residents so much. ADON stated that after providing wound care, the new wound dressing should be dated or at least should be stated verbally, this was important to know when the previous wound care was done.In an interview on 05/14/2026 at 5:26 p.m. with the ADM, he stated that he was trained in infection control; he completed CII modules last year. ADM stated that the infection control modules covered hand hygiene protocol such as sanitizing hands before and after going to the residents' rooms, staff must wash hands when hands are visibly soiled. He stated that hand hygiene was important to prevent spread of infection. He stated that if the Foley bag inside of privacy bag touched a floor, then staff can replace the privacy bag using gloves. He stated if a Foley bag had partially come out of the privacy bag then it should not be on the floor because it potentially can cause UTI.Record review of the facility's undated policy titled Wound Treatment Management did not reflect the specific requirements or instructions to label a new dressing with the date, time, and the initials of the staff who provided a wound care.The facility did not provide the wound care policy/procedures that was requested from DON at 11:46 a.m. on 05/12/2026.Record review of facility's Nursing Policy and Procedure Manual titled Perineal Care female (With or without catheter dated 2003 and revised December 8, 2009, reflected: a. Wipe across the pubis areab. Separate inner labia and using a different surface, wash down the center over the urethral area, wiping downward from front toward back and stopping at the base of labia.Record review of facility's undated Nursing Policy and Procedure Manual titled Catheter Care reflected:10. Be sure the catheter tubing and drainage bag are kept off the floor.14. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum.15. Keep drainage bag below level of bladder when cleaning the urethral area:16. Gently wash, rinse and dry around the juncture of the catheter and meatus. If using pre-moistened no-rinse disposable wash cloths, rinsing is not required)17. Then wash the catheter from the meatus down the tube about 3 inches.The facility did not provide a policy/procedure on reusable medical devices/equipment that was requested from the RCN around 7:47 a.m. on 05/14/2026.

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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 interviews, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for 1 of 8 (Resident #24) residents observed for dignity. The facility failed to ensure Resident #24 had her chin and neck hair trimmed. These failures could place residents at risk of experiencing humiliation, degradation, and a decreased quality of life.The findings included: Review of Resident #24's face sheet dated 05/14/26 reflected a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included down syndrome (genetic condition caused by the presence of an extra copy of chromosome 21 leading to developmental delays and distinct physical features), muscle weakness, and need for assistance with personal care. Review of Resident #24's quarterly MDS assessment dated [DATE] reflected a BIMS score of 02 indicating severe cognitive impairment. Section GG for functional abilities reflected a - (no information) in the areas are of:Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. Review of Resident #24's care plan last revised on 04/20/26 reflected Resident #24 has an ADL self-care performance deficit/ decreased mobility, debility, muscle weakness with interventions that included:Bathing: requires staff x1 for assistanceDressing: requires staff x1 for assistanceThe care plan did not contain information on the required level of care related to personal hygiene related to shaving. During an observation on 05/12/26 at 05:05 PM Resident #24 was observed in the hall, she was observed to have excessive chin and neck hair approximately 1/3 inch in length. During an observation and interview on 05/14/26 at 09:47 AM Resident #24 was observed in the hall self propelling in wheelchair. She was still observed to have her chin and neck hair. Resident #24 stated that she had her last shower the day before on 05/13/26, she stated staff did not assist her with grooming her chin and neck hair but have in the past. She stated she was not able to maintain it on her own. She stated having the chin and neck hair did not make her feel good and Resident #24 appeared embarrassed and to shy away from the question of someone taking notice. She stated she has told staff in the past that it bothered her. During an interview and observation on 05/14/26 at 10:25 AM with CNA P, she stated she was the CNA that cared for Resident #24 and was the CNA that provided Resident #24 with her shower on 05/13/26. She stated that Resident #24 required assistance with showers and grooming. She stated that on 05/13/26 she did not notice any facial hair on Resident #24 so she did not ask the resident if she wanted it trimmed or assist her with it. She stated if she needed to determine the type of assistance a resident required she would look on the Kardex in the residents chart and it would list what help if any they required for grooming/ personal hygiene. CNA P was observed looking at the Kardex for Resident #24 and CNA P stated she could not see anything in the Kardex indicating the level of assistance Resident #24 required, that it was not there. She stated that regardless if they see female residents with chin or facial hair they would take care of it, CNA P stated having facial hair is not feminine and could make them feel bad. At this time Resident #24 was observed self propelling in front of surveyor and CNA P and CNA P took notice of the facial hair. She once again claimed she did not notice it 05/13/26 but would take care of it. During an interview and observation on 05/14/26 at 11:05 PM with LVN Q she stated she worked with Resident #24, she stated staff were to look on the point of care to determine the assistance requirements for residents to include grooming/ shaving if its something they need help with. LVN Q sated facial hair on females has the potential to make them feel less attractive and it could affect their self-esteem; it's a dignity issue. During an interview on 05/14/26 at 11:25 AM MDS Coordinator stated that grooming related to facial hair is something that can be reflected on a care plan if the resident required assistance with it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Coordinator stated that as a woman if she had facial hair, it would make her self-conscious and was possibly a dignity issue. During an interview on 05/14/26 at 11:37 AM the DON stated she was not aware of Resident #24's facial hair and when asked how it could make a resident feel she stated it's a personal preference. She stated the level of assistance required should be listed under the category of grooming in the care plan. During an interview on 05/14/26 at 04:42 PM the Administrator, stated a negative impact of assistance not being provided with shaving to female residents was the potential to impact their emotions in a negative way. Review of the facility undated Resident Rights policy reflected: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizes each resident's individuality. The facility must protect and promote the rights of the resident.Respect and Dignity: The resident has the right to be treated with respect and dignity.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 1 (Resident #24) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure the MDS dated [DATE] was updated to reflect all of Resident #24's current functional abilities. This failure could place residents at risk of inaccurate assessments and not receiving appropriate care according to their status.Findings include: Review of Resident #24's face sheet dated 05/14/26 reflected a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included cerebral atherosclerosis (buildup of plaque in the arteries suppling blood to the brain leading to narrowed, hardened vessels and reduced blood flow), down syndrome (genetic condition caused by the presence of an extra copy of chromosome 21 leading to developmental delays and distinct physical features), muscle weakness, and need for assistance with personal care. Review of Resident #24's quarterly MDS assessment dated [DATE] reflected a BIMS score of 02 indicating severe cognitive impairment. Section GG for functional abilities- OBRA/Interim reflected a - (no information) in the following areas:Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment.Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed.Tub/shower transfer: The ability to get in and out of a tub/shower.Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.The MDS assessment reflected section GG was signed off by MDS Coordinator and the final signature was the DON under signature of RN assessment coordinator verifying assessment completion. Review of Resident #24's care plan last revised on 04/20/26 reflected Resident #24 has an ADL self-care performance deficit/ decreased mobility, debility, muscle weakness with interventions that included:Bathing: requires staff x1 for assistanceBed mobility: requires staff x1 for assistanceDressing: requires staff x1 for assistanceEating: requires staff x1 assistanceToilet use: requires staff x1 for assistanceWalking: requires staff x1 for assistanceThe care plan did not contain information on the required level of care related to personal hygiene related to shaving. During an interview and observation on 05/14/26 at 11:25 AM with MDS Coordinator, she stated the purpose of the MDS assessment was to help determine the needs of the residents and help identify care plan triggers. She stated the MDS assessment was to be updated on admission, quarterly, and annually. She stated it was the responsibility of the MDS nurse to complete and an RN would sign off on accuracy going on to say if you sign your name on it you are responsible for it. She stated it helps create an individualized care plan so the team can identify problems and where to go for interventions. The MDS coordinator stated the MDS assessment should be completed in its entirety and ADL needs should be addressed. At this time the MDS Coordinator was asked to pull up the most recent completed MDS assessment for Resident #24 and was observed reviewing the assessment dated [DATE]. The MDS Coordinator stated section GG was not completed and it should have been. During an interview on 05/14/26 at 11:37 AM with the DON, she stated that the purpose of the MDS assessment was its related to patient care, coding, and the comprehensive care plan is where it comes in. She stated it was the expectation that it was coded correctly according to the assessment (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points of Pflugerville	521 S Heatherwilde Blvd Pflugerville, TX 78660

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the nurses. She stated section GG relates to a residents functional ability. She stated that as long as a section shows green it reflected it was ready to close out and that was what she was signing off on. She stated she was attesting that its ready to be closed, she stated the MDS nurse was responsible for ensuring all sections are completed. The DON stated with Resident #24 that section GG was not intentionally left uncompleted, that it was her understanding based on a corporate directive that they did not have to complete all of section GG of the MDS assessment. She stated that along with the system giving her the green indication was why she signed off on it. A policy on MDS assessments and accuracy/ completion of assessments was requested at this time; the DON stated they did not have a policy but that they followed the RAI manual. During an interview on 05/14/26 at 4:42 PM with the Administrator, he stated it was his expectation that the MDS was accurate and reflected what was going on with the resident at the time. He stated it was the responsibility of the MDS nurse to complete it and then should be verified once signed by an RN. He stated if section GG for functional abilities is missing or changes it should be updated to be accurate. He stated the MDS assessment had the potential to affect the care plan and it could potentially affect the care provided resulting in the current care not being accurate. The Administrator confirmed that there was no current policy related to MDS assessments and that they followed the RAI manual. Record review of the CMS Final MDS 3.0 RAI Manual version 1.20.1 October 2025 reflected:Assessment of the GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking might be assessed for a resident who did/does/will use a wheelchair as their primary mode of mobility, stair activities might be assessed for a resident not routinely accessing stairs).OBRA/Interim: The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM (payment driven payment model) classification. OBRA assessments (A0310A = 01 - 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual. For Section GG on the IPA Interim Payment Assessment (IPA) or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the resident's usual functional performance during the 3-day assessment period.Coding Instructions:When coding the resident's usual performance, use the six-point scale, or use one of the four activity was not attempted codes to specify the reason why an activity was not attempted.A dash (-) indicates No information. CMS expects dash use to be a rare occurrence.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it was free of a significant medication error for 1 of 1 (Resident # 74) resident reviewed for pharmacy services.The facility failed to ensure Resident # 74 received scheduled medication within the ordered liberalized time range: 07:00am-09:00am, 11:30am-2:00pm, 6:30pm-10:30pmThis deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization.Findings Included:Record review of Resident #74's undated face sheet reflected a 65-year female was admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations (refers to the early or stable phases of the disease where patients maintain predictable symptom control without involuntary movements or off/on medication swings), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline that impacts daily life, but lacks co-occurring behavioral, psychiatric, or mood issues), unspecified abnormalities of gait and mobility (walking or movement difficulties e.g., shuffling, limping, imbalance where the precise underlying cause is not yet identified or documented), need for assistance with personal care (need for help with activities of daily living).Record review of Resident #74's quarterly MDS assessment dated [DATE] reflected no BIMS due to the MDS not yet being completed. Resident #74's cognitive skills for daily decision-making assessment reflected: Severely impaired - never/rarely made decisions.Record review of Resident #74's undated care reflected:Resident #74' has Parkinson's -Date Initiated: 12/07/2024 Goal included- will remain free of further s/sx, discomfort or complications related to Parkinson's disease through review date. -Date Initiated: 11/20/2025. Interventions included- Give medications as ordered by the physician. Monitor/document side effects and effectiveness.-Date Initiated: 12/07/2024. Monitor/document/report to MD PRN any s/sx of aspiration or dysphagia: choking, fever, coughing. Refer to ST for any dysphagia problems.-Date Initiated: 12/07/2024. Monitor/document/report to MD PRN s/sx of Parkinsons complications: Poor balance, constipation, poor coordination, insomnia, dysphagia, tremors, gait disturbance, incontinence, muscle cramps or rigidity, decline in ROM, skin breakdown, mood changes, decline in cognitive function.-Date Initiated: 12/07/2024. Resident #74 has impaired cognitive function and impaired thought processes r/t dementia.-Date Initiated: 11/25/2024. Goal included-Resident #74 will maintain current level of cognitive function through the review date.-Date Initiated: 11/20/2025. Interventions included- Administer meds as ordered.-Date Initiated: 11/25/2024. Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. -Date Initiated: 11/25/2024.Record review of^Resident #74's^order^summary report^reflected:-Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa). Give 1 tablet by mouth three times a day for Parkinsonrelated to Parkinson disease without dyskinesia, without mention of fluctuations. Start date: 01/17/2025. Record review of Resident # 74's scheduling details reflected:Medication: Carbidopa-Levodopa Oral Tablet 25-100 MG.Medication class: Antiparkinson and related therapy agents.Dose of administrating quantity:1Frequency: Three times a day.Schedule type: Every day.Facility Time code: TID LibRelated diagnosis: Parkinson's disease without dyskinesia, without mention of fluctuations.For (indications for use): Parkinson.Time Range(s): 07:00am-09:00am, 11:30am-2:00pm, 6:30pm-10:30pmRecord review of Resident # 74's Carbidopa-Levodopa Oral Tablet 25-100 MG medication administration audit report from 04/01/2026 to 05/14/2026 reflected Resident # 74 received the medication Carbidopa-Levodopa Oral Tablet 25-100 MG earlier than the liberalized medication pass time of 07:00 a.m.-09:00 a.m. on: 04/01/2026 at 06:20 a.m.,04/02/2026 at 06:17 a.m., 04/03/2026 at 06:09 a.m., 04/04/2026 at 06:01 a.m., 04/05/2026 at 06:45 a.m., 04/06/2026 at 06:09 a.m.,04/2026 at 06:29 a.m., 04/12/2026 at 06:38 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., 04/15/2026 at 06:27 a.m., 04/16/2026 at 06:35 a.m., 04/21/2026 at 06:36 a.m., 04/22/2026 at 06:31 a.m., 04/24/2026 at 06:27 a.m., 04/25/2026 at 06:09 a.m., 04/26/2026 at 06:08 a.m., 04/27/2026 at 06:15 a.m., 05/02/2026 at 06:18 a.m., 05/03/2026 at 06:30 a.m., and 05/13/2026 at 06:30 a.m.Resident # 74 received the medication Carbidopa-Levodopa Oral Tablet 25-100 MG later than the liberalized (flexible schedule) medication pass time of 07:00 a.m.-09:00 a.m. on: 04/14/2026 at 11:17 a.m., 04/17/2026 at 11:30 a.m., 04/18/2026 at 12:16 p.m., 04/20/2026 at 10:48 a.m., and 05/06/2026 at 10:49 a.m.Resident # 74 received medication Carbidopa-Levodopa Oral Tablet 25-100 MG earlier than the liberalized medication pass time of 11:30 am-2:00 pm on: 04/01/2026 at 11:18 a.m., 04/02/2026 at 11:12 a.m., 04/03/2026 at 11:15 a.m., 04/08/2026 at 10:58 a.m., 04/10/2026 at 11:10 a.m., 04/13/2026 at 11:23 a.m., 04/14/2026 at 11:25 a.m., 04/15/2026 at 11:04 a.m., 04/17/2026 at 11:30 a.m., 04/21/2026 at 11:16 a.m., 04/22/2026 at 11:07 a.m., 04/24/2026 at 10:58 a.m., 04/25/2026 at 10:31 a.m., 04/27/2026 at 11:16 a.m., 04/30/2026 at 11:02 a.m., 05/01/2026 at 11:49 a.m., 05/03/2026 at 10:52 a.m., 05/06/2026 at 10:49 a.m., 05/11/2026 at 10:48 a.m., and 05/12/2026 at 10:55 a.m.Resident # 74 received medication Carbidopa-Levodopa Oral Tablet 25-100 MG earlier than the liberalized medication pass time 6:30 pm-10:30 p.m. on: 04/05/2026 at 5:59 p.m., 04/06/2026 at 5:46 p.m., 04/10/2026 at 6:09 p.m., 04/24/2026 at 6:20 p.m., 04/28/2026 at 6:16 p.m., 05/01/2026 at 6:14 p.m., 05/04/2026 at 6:02 p.m., 05/06/2026 at 6:19 p.m., and 05/10/2026 at 6:19 p.m.Record review of Resident # 74's medication administration audit report reflected she received her medication Carbidopa-Levodopa medication 56 times outside of the liberalized medication pass time order from 04/01/2026 to 05/14/2026. Resident # 74 received double doses of the medication due to the morning medication dose of Carbidopa-Levodopa being administered with the afternoon medication dose simultaneously or too close to each other: On 04/14/2026-the morning dose was administered at 11:17 a.m. and the afternoon dose was administered at 11:25 a.m. On 04/17/2026 -the morning dose was administered at 11:30 a.m. and the afternoon dose was administered at 11:30 a.m. On 04/18/2026 -the morning dose was administered at 12:16 p.m. and the afternoon dose was administered at 12:16 p.m. On 04/20/2026 -the morning dose was administered at 10:48 a.m. and the afternoon dose was administered at 1:13 p.m. On 05/01/2026 -the morning dose was administered at 09:34 a.m. and the afternoon dose was administered at 11:49 a.m. On 05/06/2026 -the morning dose was administered at 10:49 a.m. and the afternoon dose was administered at 10:49 a.m. On 05/10/2026 -the morning dose was administered at 09:45 a.m. and the afternoon dose was administered at 12:16 p.m.During interview on 05/14/2026 at 3:30 p.m. with NP, she stated that medications should be administered within an hour before or an hour after the scheduled time, administering Sinemet (carbidopa/levodopa) medication 2 hours later can cause tremors and dyskinesia. She stated giving this medication close to two doses would affect residents. She stated it was better when the doses are separated out. She stated she prefers there to be a bigger medication gap between when medication is administered, and she would want to be notified so she can make changes to the dosing time schedule.During an interview on 05/14/26 at 5:30 p.m. with the ADM, he stated if Parkinson's medication (Carbidopa-Levodopa) was late all the time then residents could have increased tremors, and it would affect their therapy. He stated that dyskinesia (movement disorders characterized by involuntary, erratic, and uncontrollable muscle movements, such as fidgeting, writhing, twisting, or jerking) can affect therapy and eating. He stated if the medication was administered constantly late, it affects residents psychosocially.During an interview on 05/15/2026 at 11:26 a.m. with the MD, she stated that she did not know anything about Sinemet (Carbidopa/Levodopa) medication. She stated that it should be consistent with the time, and she would not recommend the liberalized time administration for this medication. She stated if it was a multi-vitamin then it could be liberalized but if a resident is getting 2 or 3 doses, something given 3 times a day should not be liberalized because there was a chance of doses being given too close together, and the resident could have adverse effect of being overdosed and medication was not meant to be given that way. She stated the Parkinson's medication should be given 3 times a day. She stated that this has been written by the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurologist, and if they were at home, they would get it when they woke up - if they were at home the medications could not be given every 8 hours because the medication was given 3 times a day, and they were getting it 3 times a day. She stated that it works better if the medication was given 3 times every 8 hours around the clock, but that would not happen if they were at home.During an interview on 05/15/2026 at 12:32 p.m. with the DON, she stated liberalized time for medications was a window time; morning time means you can give the morning medication 6:30 a.m. - 10:30 a.m. - it was given a bigger window to administer the medications. She stated the Sinemet (Carbidopa-Levodopa) medication should not be liberalized. She stated that the MD controls liberalized timing. She stated if it is liberalized medication, then there was a window of 4 hours, technically the medication could be given an hour before or an hour later outside of the window. She stated, If the morning medication was given at 11:00 a.m. or 11:30 a.m., and the next medication was given at 12:00 p.m., then it would be considered a double dose. She stated, in nursing, if the same medication is given 30 minutes apart, that is considered double dosing, and nursing judgment is not to give at the same time. She stated that if medication is given too close together, they would have a big side effect, and she has not seen it. She stated nurses were not documenting the given medication immediately in the MAR, and if they are documenting all medications given at the end of their shifts, it makes look like a dose to dose. She stated that when the liberalization policy changed the staff was in-serviced in new policy.During an interview on 05/15/2026 at 1:32 p.m. with the RNC, she stated that when medication times were liberalized, they cannot go beyond the time frame. It would be an error if the medication was given 60 minutes earlier or after the liberalized medication time; it would be a medication error if the liberalized medication was given outside of the liberalized time range. She stated if a nurse calls the doctor and tells the doctor that a resident wants her morning and evening medication given together and the doctor gives the okay to do so, it would be documented in the progress note. Carbidopa-Levodopa medication is used to control tremors, rigidity, and muscle spasms in patients with Parkinson's. She stated that this medication was time sensitive; it is extended release. She stated she expected nurses and med aides to give medication as ordered. RNC stated that If Carbidopa-Levodopa was not given on time, she did not believe it would impact the resident if they missed the dose, but the doctor must be notified about the missed dose and the doctor will be giving an order, and nurses was expected to follow those directions. She stated that she doesn't expect missed doses to happen often, it is not a current practice to give the same medication an hour apart from one another, a med aide should let her nurse know before giving medication too close together. The med aide was expected to communicate with the nurse; the nurse then will communicate it to the doctor and then document that she contacted the doctor.Record review of the facility's Pharmacy Policy and Procedure, titled Liberalized Medication Policy dated 2006 and revised 01.06.2026 reflected: We are expanding the allotted time for some medications to be given using the AM, PM, AM/PM and TID lib time codes.This will impact medications scheduled in the morning, afternoon and in the evening and two-three times per day medication orders.TID lib= may be given from 6:30 am-10:30 am, 11:30 am-2 pm, 6:30pm-10:30pmTID lib time code-combining the three-time parameters set above. This indicates a medication is set to be given three times per dayIf a physician's order specifically states the time of day a medication is to be given, then the facility must administer it at the time specified.The facility could continue to have traditional times for any medication scheduled more than 2-3 times per day, i.e. QID, Q6H, Q4H, etc.There are some medications that are to be given every day that will be given at a specific time such as Synthroid. These will continue to be given at a time as suggested by the manufacturer and current industry practices.The DON, Consultant Pharmacist, Medical Director, and any other members of the clinical team deemed necessary have reviewed and approved the liberalized medication pass policy and procedure and will review each resident's medications and adjust medication administration times if needed based on ISMP High Alert Medication list and other current standards of practice.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 2 of 8 residents (Resident #32 and Resident #50) reviewed for dietary services. 1. The facility failed to ensure Resident #32 received his prescribed diet of pureed texture. 2. The facility failed to ensure Resident #50 received his prescribed diet of mechanical soft texture. These failures placed residents at risk of choking, aspiration (inhaling food), and diminished quality of life. Findings included: 1. A record review of Resident #32's face sheet dated 5/14/2026 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of Parkinson's disease (neurological disorder), protein-calorie malnutrition, muscle weakness, muscle wasting and atrophy (muscle loss), need for assistance with personal care, unspecified abnormalities of gait and mobility. A record review of Resident #32's MDS assessment dated [DATE] reflected a BIMS of 6, which indicated severely impaired cognition. Resident #32's MDS assessment reflected that she required substantial/maximal assistance with eating. A record review of Resident #32's care plan last revised on 5/07/2026 reflected that she had complained of chewing problems and her diet was changed to a pureed texture. Intervention included to provide and serve diet as ordered. A record review of Resident #32's orders reflected an order dated 5/06/2026 for a pureed diet. An observation on 5/12/2026 at 12:31 PM revealed Resident #32 was sitting at the dining room table with a plate of pureed food in front of her. Resident #32 was not eating, her plate was untouched, and she had a brownie near her plate. An observation on 5/12/2026 at 12:32 PM revealed the SLP came by Resident #32's table, picked up the brownie, and walked away. During an interview on 5/12/2026 at 12:33 PM, the SLP stated, no she did not know why Resident #32 was served a brownie when she was on a pureed diet and that was why she took the brownie away. The SLP stated that sometimes the special instructions on the tray ticket did not change when diets were updated. During an observation and interview on 5/14/2026 at 12:02 PM, Resident #32 was observed sitting in the dining room. Resident #32 stated that she had not had any incidents of choking. During an interview on 5/14/2026 at 12:06 PM, CK M stated that he worked on 5/12/2026 and he figured the brownie for Resident #32 was soft enough. During an interview on 5/14/2026 at 1:22 PM, the SLP stated that she changed Resident #32's diet order because of her involuntary movements. The SLP stated that Resident #32 would have been okay if she ate the brownie. During an interview on 5/14/2026 at 12:44 PM, the DON stated that dietary and nursing checked trays during meal service to make sure the diet matched what was served. The DON stated that Resident #32's diet was recently changed but the note on her ticket, which reflected that she was to be served a brownie, was not removed. The DON stated that the Dietary Manager trained staff on texture-modified diets. The DON stated that if residents on a pureed diet ate regular textured foods, they could cough or choke. During an interview on 5/14/2026 at 4:55 PM, the Administrator stated that the Dietary Manager trained dietary staff on food consistency and that nurses checked for tray accuracy during meals to make sure that residents on a pureed diet were not served a regular diet. When asked how residents could be impacted if they were not served meals according to their diet order, the Administrator stated they would be at risk for choking. 2. A record review of Resident #50's face sheet dated 05/14/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of cerebral palsy (lifelong condition caused by brain damage or abnormal development, affecting a person's ability to move, maintain posture, and balance), major depressive disorder (a severe mood disorder causing persistent feelings of sadness, hopelessness, and a loss of interest in activities), and anemia (body lacks enough healthy red blood cells or hemoglobin to carry adequate oxygen to your tissues). A record review of Resident #50's MDS assessment dated [DATE] reflected a no BIMS score; the resident was rarely/never understood. A record review of Resident #50's care plan last revised on 05/12/2026 reflected a focus of Resident #50 was at risk for choking (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to chewing problem, diet - mechanical soft texture with intervention dated 09/09/2021 CNA to report to nurse any signs of resident choking. Observation on 05/12/2026 at 6:03 PM revealed Resident #50 alone in his room with a firm, not soft cookie on his dinner tray. Observed that when the cookie was turned on its side and tapped against the tray, it did not bend but remained hard. Observation on 05/13/2026 at 7:55 AM revealed Resident #50 alone in his room with a solid round sausage patty on his breakfast tray. During an interview with an interpreter on 05/13/2026 at 12:44 PM with CNA R, she said if something looked too hard or chewy on Resident #50's plate they had to notify the kitchen and get substitute food. CNA R said Resident #50 did not eat in the dining room because he preferred to eat in his room and no one could get him to eat in the dining room. CNA R said if she was concerned about something that was on Resident #50's plate she would immediately notify the nurse who oversaw reviewing his food. CNA R said when the food came out of the kitchen a nurse reviewed it before the food was distributed. During an interview on 05/14/2026 at 1:16 PM the DOR/SLP said a sausage patty and firm cookie should not have been on Resident #50's food trays. The DOR/SLP said Resident #50 should have a regular diet and naturally soft, finely chopped, ground food. The DOR/SLP said he should not have hard cookies or food that was not finely chopped because he might aspirate (inhaling food that is not properly cut or chewed is a significant risk, as large, solid pieces can block the airway or lead to pneumonia if they reach the lungs) or choke. The DOR/SLP said it was the responsibility of all the staff to make sure Resident #50 got the correct diet on his meal tray. During an interview on 05/14/2026 at 2:01 PM with the Cook, he said the kitchen checked resident trays for the food to make sure it matched the diet of the residents. The [NAME] said sometimes things got on the resident's tray that should not have been on the tray and they tried to fix it as soon as they found it. The [NAME] said he learned that the cookies should be ground up crumbly. The [NAME] said that on 05/12/2026 the menu listed they were going to serve cupcakes but instead they served the harder round cookie instead of the soft cupcake. During an interview on 05/14/2026 at 1:12 pm the DON said Resident #50 was care planned for a regular mechanical soft diet and he should not have the round, not cut up sausage for breakfast. The DON said the possible negative effect of Resident #50 not having food that was mechanical soft was that there was a possibility he could choke.Record review of facility policy Meal Service and Snacks, undated, reflected diets such as regular, renal (relating to, involving, or located in the region of the kidneys), and diabetic may be combined with texture modification or other consistency changes. All modifications are based upon the residents' needs. Cut up or shopped meats or other foods are provided when the resident requires them. Ground consistency involved the actual grinding of meat or other specified food, usually through a food grinder or processor. Frequently, meat is the only food that needs to be ground. Ground foods are served to residents with chewing or swallowing problems