

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2024
NAME OF PROVIDER OR SUPPLIER North Pointe Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7804 Virgil Anthony Blvd Watauga, TX 76148	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect for one of two residents (Resident #1) reviewed for suicidal ideation. The facility failed to put measures in place when Resident #1 admitted to the facility with the diagnosis of suicidal ideation. On 08/15/24, Resident #1 reported to facility that she drank hand sanitizer from a small pocket-sized bottle and wanted to kill herself. An IJ was identified on 08/15/24. The IJ template was provided to the facility on [DATE] at 3:48 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. The failure placed residents at risk for neglect. Findings included: Review of Resident #1's face sheet printed on 08/17/24 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, major depressive disorder, post-traumatic stress disorder, adjustment disorder with anxiety, conversion disorder with sensory symptom (condition where a mental health issue causes physical symptoms), moderate intellectual disabilities, autistic disorder, and suicidal ideation. Review of Resident #1's New Referral documentation dated 07/30/24, sent from the prior nursing facility where Resident #1 resided at, reflected one of the resident's diagnoses was suicidal ideation. Further review of Resident #1's referral documentation reflected there was a progress note dated 07/23/24 which reflected: Resident is having suicidal attempts, suicidal thoughts. Sent to [Hospital] for further treatment. Notified the Legal Guardian. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's baseline care plan initiated on 08/06/24 reflected Resident #1 had attention seeking behaviors as evidenced by not allowing staff to maintain professional boundaries. Resident would go into multiple staff offices with no regard with what is going on in the office such as meetings with other residents or families and attempt to talk to staff regarding resident's personal life and history for hours at a time. When staff reinforce professional boundaries resident thinks staff do not like her or are being mean to her and make allegations. Interventions included to monitor behavior episodes and attempts to determine underlying cause. Document behavior and potential causes. Further review of the baseline care plan revealed there was no diagnosis of suicide ideation. Review of a statement from the facility's Provider Investigation Report, dated 08/15/24, documented by the Administrator in Training reflected the following: At approximately 8:30 AM on 08/15/24, I was standing at the nurse's station when [Resident #1] wheeled up to me with a liquid staining on the front of the shirt. She showed me a small personal hand sanitizer bottle and said that she drank it. The bottle was approximately 1/4 full. She said that she drank it to kill herself then expressed a series of similar suicidal ideations. I immediately provided 1:1 attention to her while the nursing staff contacted emergency services. The staff offered her water and milk, but the resident refused despite prompting from multiple staff, including myself. I remained with the resident until emergency services arrived approximately 15 minutes later. Although I observed the resident expressing sadness and making weeping sounds, I did not witness any tears throughout the time period that I interacted with her. Review of Resident #1's progress notes dated 08/15/24 documented by LVN A reflected the following: Resident at nurses desk states she swallowed a bottle of hand sanitizer, Resident states she wanted to kill herself. Resident places on one on one. DON present. Resident very upset. She is alert and oriented. New order to send resident to hospital. Resident sent to [Hospital]. Her conservator notified Interview on 08/15/24 at 9:34 AM with LVN A revealed Resident #1 had gone to the hospital the evening before, 08/14/24, due to feeling ill and she got report from the previous charge nurse that Resident #1 had wrote on her hospital discharge paperwork, scribbled out some of her diagnoses and wrote other in. LVN A said it appeared Resident #1 became upset when she was asked why she had written on her discharge paperwork. A while later after LVN A had finished getting report from the previous charge nurse, LVN A was at the nurse's station and Resident #1 approached her, holding a small bottle of hand sanitizer and said, I hope everyone is happy. I just drank this. LVN A said the bottle of hand sanitizer still had about a 1/4 left inside. The DON was also at the nurse's station at the time, and they called 911 and the resident's guardian. Resident #1 was visibly upset, and she was offered milk which she refused, and she was monitored until she was transferred to the hospital. LVN A further stated Resident #1 sought out attention from the staff, would report one ailment after another and if they took too long to respond, Resident #1 would begin to say people did not like her and she was going to be kicked out of the facility. LVN A further stated Resident #1 had not expressed any suicidal ideations prior to the incident on 08/15/24. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 11:15 AM with the Administrator in Training revealed he was at the nurses' station the day of the incident, 08/15/24 and heard Resident #1 call for him and wheeled towards him very quickly. The front of Resident #1's shirt looked like she had vomited or spit something out of her mouth, and the resident held up a small, pocket size bottle of hand sanitizer. The resident stated she had drunk the sanitizer and wanted to die. The bottle of sanitizer appeared to have about a quarter left inside. LVN A and the DON were also at the nurses' station when the incident occurred, and they stayed with the resident 1:1 until 911 was contacted. While they waited for EMS to arrive, Resident #1 continued to say she wanted to die even if she went to hell because no one loved her, and she did not belong in heaven. Resident #1 was transferred to the hospital for further evaluation. The Administrator in Training said he had a lot of contact with Resident #1 prior to the incident and said the resident did not respect boundaries and made her way into staff offices, even if they were with other residents or families. When the resident would be reminded of the boundaries, she would become upset stating no one loved her even when they would try to reassure her. The Administrator in Training further stated Resident #1's moods were very unpredictable and described them as lows and highs but the resident had never expressed suicidal ideations. Interview on 08/16/24 at 10:08 AM with the Social Worker revealed Resident #1 had attention seeking behaviors and did not have a lot of boundaries towards others. She said the resident was upbeat for the most part and had never expressed suicidal ideations during her stay. The day of the incident, 08/15/24, Resident #1 had already handed the sanitizer to the nursing staff and she was being monitored until the resident was transferred to hospital. The Social Worker stated she was not aware the resident has a diagnosis of suicidal ideations and had she seen that on the face sheet, that would have been a red flag to look into the matter further to put appropriate measure in place. The Social Worker said Resident #1 had a guardian that had been appointed to her in April 2024, who told her after the incident, that Resident #1 had previously tried to drink mouthwash and swallowed a keychain in an attempt to harm herself. Interview on 08/16/24 at 10:54 AM with Resident #1's guardian revealed she had taken over as legal guardian for Resident #1 in April 2024, because her family could no longer do it. She said shortly after either late April or early May, Resident #1 had expressed suicidal ideations and had drank mouthwash and swallowed a keychain. The resident was transferred to the hospital where they had to do an endoscopy to remove the keychain. While Resident #1 was at the previous facility, she continuously called 911 wanting to be taken to the emergency room for various reasons. The resident was given a 30-day discharge notice from the previous facility and when she was transferred to the current facility, she forgot to tell the facility about the mouthwash and keychain incident because there were so many things going on with Resident #1's behaviors. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 11:26 AM with the DON revealed after Resident #1 was admitted she began to make accusations against staff stating they did not like her. The resident was attention seeking and would enter staff offices even if they were busy with other staff or residents wanting to talk about her childhood life. The day of the incident, 08/15/24, Resident #1 was at the nurse's station, upset, stating no one liked her because she had been questioned about writing on her hospital discharge paperwork from the day prior. Resident #1 had scribbled out some of her diagnoses and handwritten others and when she was questioned about it, she became upset, cried and rolled away from the nurse's station. The DON said Resident #1 returned back to the nurse's station holding a pocket size hand sanitizer and said she had drank it because she wanted to die. The resident made the statement that she had googled if she drank enough of the hand sanitizer it would kill her that she has in her personal belongings. They immediately called 911 as the resident continued to say she wanted to die. Initially Resident #1 refused to go to the hospital but eventually was transferred out. The DON further stated new admission paperwork was reviewed by the Administrator, the ADON and herself and she did not see the diagnosis of suicidal ideations or read the note where Resident #1 had suicide attempts. The DON said if she would have seen that, she probably would have recommended Resident #1 to a psychiatric facility instead of admitting her to their facility. Interview on 08/16/24 at 11:40 AM with the ADON revealed Resident #1 was very talkative and was attention seeking. As the days went by, the attention seeking escalated and the resident would go around asking for hugs and kisses, asking people if they liked her. The day of the incident, 08/15/24, when she got to work, Resident #1 was at the nurse's station and there were a couple of staff around the resident and she had already drank the hand sanitizer. Resident #1 continued to state no one liked her. The ADON said she had read Resident #1's referral before she was admitted, and the documentation had not painted the real picture of who the resident really was. The ADON further stated she did not see the suicidal ideation diagnosis, or the progress note of an attempt. She said if she would have seen that she would have notified the department heads because the facility was possibly not the place for the resident. Interview on 08/16/24 at 12:11 PM with the MDS Nurse revealed he had created Resident #1's face sheet for the facility and copied the resident's diagnoses from the previous facility's face sheet including the diagnosis of suicidal ideation. The MDS Nurse said he did not tell anyone about the suicidal ideation because he assumed they were all aware. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 8:15 AM with the Administrator revealed Resident #1 was transferred from another nursing facility. They were not aware until after the resident's incident, 08/15/24, that the resident had been given a 30-day discharge notice. After the resident arrived, she started to want a lot of one-on-one attention from the staff. On Wednesday, 08/14/24, Resident #1 began to complain of stomach issues and after she had been given medication, the resident then escalated her stomach symptoms to saying she had chest pains. Resident #1 was assessed, and her vitals were within normal range but she was sent to the hospital and returned shortly with no new orders. The Administrator said Resident #1 was making statements the morning of 08/15/24 saying everyone hated her and she was going to get kicked out of the facility. Resident #1 later went to the nurse's station and told staff she had drank hand sanitizer from a pocket size bottle she was holding stating she wanted to kill herself. There appeared to be some on her shirt, so they were not aware how much she had consumed so they called 911 and she was transferred out for evaluation. The Administrator further stated she had seen the suicidal ideation on the face sheet before Resident #1 has been admitted but she did not know how long ago it had taken place and when she had reviewed the referral she had not read anything recent that implied the resident had attempted suicide. No one was asked about her past and they were just going off of what was in the recent notes. Review of the facility's Abuse/Neglect policy, revised 03/29/18, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the this subpart The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property and situations that may constitute abuse or neglect to any resident in the facility. An Immediate Jeopardy/Immediate Threat was identified on 08/16/24. The Administrator and the Regional RN were notified of the Immediate Jeopardy on 08/16/24 at 3:33 PM. The IJ template was provided to the facility on [DATE] at 3:48 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 08/17/24 at 9:50 AM and reflected the following: F600 Abuse and Neglect The facility failed to ensure a resident had the right to be free of neglect when a resident with a documented diagnosis of suicidal ideation reported that she wanted to kill herself and ingested a small amount of hand sanitizer. Interventions: 1. As of 8/16/24, Resident #1 remains in the hospital for evaluation. 2. All resident rooms were inspected by the Administrator, DON, and ADON for hazardous items that are not allowed in resident rooms as of 8/16/24. All pocket hand sanitizers have been removed from resident rooms and common areas. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 08/17/24 from 11:17 AM to 2:19 PM from staff from various shifts were Administrator, Administrator in Training, DON, ADON, Social Worker, MDS Nurse, BOM, Marketer, Medical Records, Maintenance Director, Dietary Aide, Laundry Aide LVN's A, B, C and D, RNs I, J, K, CNAs E, F, G, H, MAs N, O, Housekeeping L, M. All staff were able to identify the following: - The different types of abuse. - What do if they see a resident showing signs of distress or hear a resident verbalizing harm to themselves or stating they want to die. - What hazardous items not allowed in resident rooms and what to do if they find them. LVN's A, B, C, D and RNs I, J, K were able to explain what to do if a resident was admitted with a diagnosis of suicidal ideation. The Administrator, DON, and ADON were provided in-service to review all resident diagnoses before they are admitted and to put the proper interventions in place for each resident. An IJ was identified on 08/15/24. The IJ template was provided to the facility on [DATE] at 3:48 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent the neglect of residents for one of two residents (Resident #1) reviewed for neglect. The facility failed to implement the facility's written policies and procedures to prohibit and prevent neglect of Resident #1. The facility failed to put measures in place when Resident #1 admitted to the facility with the diagnosis of suicidal ideation. On 08/15/24, Resident #1 reported to facility that she drank hand sanitizer from a small pocket-sized bottle and wanted to kill herself. After administrative review, an IJ was identified on 08/29/24. The IJ template was provided to the facility on [DATE] at 4:31 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. The failure placed residents at risk for neglect. Findings included: Review of the facility's Abuse/Neglect policy and procedure, dated 03/29/18, reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .The facility will provide and sure the promotion and protection of resident rights. It is each individuals' responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, and mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Definitions .7. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. .B. Training The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly. .C. Prevention The facility will provide the residents, families, and staff an environment free from abuse and neglect. .D. Identification (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. .G. Protection The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property investigation Review of Resident #1's face sheet printed on 08/17/24 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, major depressive disorder, post-traumatic stress disorder, adjustment disorder with anxiety, conversion disorder with sensory symptom (condition where a mental health issue causes physical symptoms), moderate intellectual disabilities, autistic disorder, and suicidal ideation. Review of Resident #1's New Referral documentation dated 07/30/24, sent from the prior nursing facility where Resident #1 resided at, reflected one of the resident's diagnoses was suicidal ideation. Further review of Resident #1's referral documentation reflected there was a progress note dated 07/23/24 which reflected: Resident is having suicidal attempts, suicidal thoughts. Sent to [Hospital] for further treatment. Notified the Legal Guardian. Review of Resident #1's baseline care plan initiated on 08/06/24 reflected Resident #1 had attention seeking behaviors as evidenced by not allowing staff to maintain professional boundaries. Resident would go into multiple staff offices with no regard with what is going on in the office such as meetings with other residents or families and attempt to talk to staff regarding resident's personal life and history for hours at a time. When staff reinforce professional boundaries resident thinks staff do not like her or are being mean to her and make allegations. Interventions included to monitor behavior episodes and attempts to determine underlying cause. Document behavior and potential causes. Further review of the baseline care plan revealed there was no diagnosis of suicide ideation. Review of a statement from the facility's Provider Investigation Report, dated 08/15/24, documented by the Administrator in Training reflected the following: At approximately 8:30 AM on 08/15/24, I was standing at the nurse's station when [Resident #1] wheeled up to me with a liquid staining on the front of the shirt. She showed me a small personal hand sanitizer bottle and said that she drank it. The bottle was approximately 1/4 full. She said that she drank it to kill herself then expressed a series of similar suicidal ideations. I immediately provided 1:1 attention to her while the nursing staff contacted emergency services. The staff offered her water and milk, but the resident refused despite prompting from multiple staff, including myself. I remained with the resident until emergency services arrived approximately 15 minutes later. Although I observed the resident expressing sadness and making weeping sounds, I did not witness any tears throughout the time period that I interacted with her. Review of Resident #1's progress notes dated 08/15/24 documented by LVN A reflected the following: (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident at nurses desk states she swallowed a bottle of hand sanitizer, Resident states she wanted to kill herself. Resident places on one on one. DON present. Resident very upset. She is alert and oriented. New order to send resident to hospital. Resident sent to [Hospital]. Her conservator notified Interview on 08/15/24 at 9:34 AM with LVN A revealed Resident #1 had gone to the hospital the evening before, 08/14/24, due to feeling ill and she got report from the previous charge nurse that Resident #1 had wrote on her hospital discharge paperwork, scribbled out some of her diagnoses and wrote other in. LVN A said it appeared Resident #1 became upset when she was asked why she had written on her discharge paperwork. A while later after LVN A had finished getting report from the previous charge nurse, LVN A was at the nurse's station and Resident #1 approached her, holding a small bottle of hand sanitizer and said, I hope everyone is happy. I just drank this. LVN A said the bottle of hand sanitizer still had about a 1/4 left inside. The DON was also at the nurse's station at the time, and they called 911 and the resident's guardian. Resident #1 was visibly upset, and she was offered milk which she refused, and she was monitored until she was transferred to the hospital. LVN A further stated Resident #1 sought out attention from the staff, would report one ailment after another and if they took too long to respond, Resident #1 would begin to say people did not like her and she was going to be kicked out of the facility. LVN A further stated Resident #1 had not expressed any suicidal ideations prior to the incident on 08/15/24. Interview on 08/16/24 at 11:15 AM with the Administrator in Training revealed he was at the nurses' station the day of the incident, 08/15/24 and heard Resident #1 call for him and wheeled towards him very quickly. The front of Resident #1's shirt looked like she had vomited or spit something out of her mouth, and the resident held up a small, pocket size bottle of hand sanitizer. The resident stated she had drunk the sanitizer and wanted to die. The bottle of sanitizer appeared to have about a quarter left inside. LVN A and the DON were also at the nurses' station when the incident occurred, and they stayed with the resident 1:1 until 911 was contacted. While they waited for EMS to arrive, Resident #1 continued to say she wanted to die even if she went to hell because no one loved her, and she did not belong in heaven. Resident #1 was transferred to the hospital for further evaluation. The Administrator in Training said he had a lot of contact with Resident #1 prior to the incident and said the resident did not respect boundaries and made her way into staff offices, even if they were with other residents or families. When the resident would be reminded of the boundaries, she would become upset stating no one loved her even when they would try to reassure her. The Administrator in Training further stated Resident #1's moods were very unpredictable and described them as lows and highs but the resident had never expressed suicidal ideations. Interview on 08/16/24 at 10:08 AM with the Social Worker revealed Resident #1 had attention seeking behaviors and did not have a lot of boundaries towards others. She said the resident was upbeat for the most part and had never expressed suicidal ideations during her stay. The day of the incident, 08/15/24, Resident #1 had already handed the sanitizer to the nursing staff and she was being monitored until the resident was transferred to hospital. The Social Worker stated she was not aware the resident has a diagnosis of suicidal ideations and had she seen that on the face sheet, that would have been a red flag to look into the matter further to put appropriate measure in place. The Social Worker said Resident #1 had a guardian that had been appointed to her in April 2024, who told her after the incident, that Resident #1 had previously tried to drink mouthwash and swallowed a keychain in an attempt to harm herself. (continued on next page)		

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 10:54 AM with Resident #1's guardian revealed she had taken over as legal guardian for Resident #1 in April 2024, because her family could no longer do it. She said shortly after either late April or early May, Resident #1 had expressed suicidal ideations and had drank mouthwash and swallowed a keychain. The resident was transferred to the hospital where they had to do an endoscopy to remove the keychain. While Resident #1 was at the previous facility, she continuously called 911 wanting to be taken to the emergency room for various reasons. The resident was given a 30-day discharge notice from the previous facility and when she was transferred to the current facility, she forgot to tell the facility about the mouthwash and keychain incident because there were so many things going on with Resident #1's behaviors. Interview on 08/16/24 at 11:26 AM with the DON revealed after Resident #1 was admitted she began to make accusations against staff stating they did not like her. The resident was attention seeking and would enter staff offices even if they were busy with other staff or residents wanting to talk about her childhood life. The day of the incident, 08/15/24, Resident #1 was at the nurse's station, upset, stating no one liked her because she had been questioned about writing on her hospital discharge paperwork from the day prior. Resident #1 had scribbled out some of her diagnoses and handwritten others and when she was questioned about it, she became upset, cried and rolled away from the nurse's station. The DON said Resident #1 returned back to the nurse's station holding a pocket size hand sanitizer and said she had drank it because she wanted to die. The resident made the statement that she had googled if she drank enough of the hand sanitizer it would kill her that she has in her personal belongings. They immediately called 911 as the resident continued to say she wanted to die. Initially Resident #1 refused to go to the hospital but eventually was transferred out. The DON further stated new admission paperwork was reviewed by the Administrator, the ADON and herself and she did not see the diagnosis of suicidal ideations or read the note where Resident #1 had suicide attempts. The DON said if she would have seen that, she probably would have recommended Resident #1 to a psychiatric facility instead of admitting her to their facility. Interview on 08/16/24 at 11:40 AM with the ADON revealed Resident #1 was very talkative and was attention seeking. As the days went by, the attention seeking escalated and the resident would go around asking for hugs and kisses, asking people if they liked her. The day of the incident, 08/15/24, when she got to work, Resident #1 was at the nurse's station and there were a couple of staff around the resident and she had already drank the hand sanitizer. Resident #1 continued to state no one liked her. The ADON said she had read Resident #1's referral before she was admitted, and the documentation had not painted the real picture of who the resident really was. The ADON further stated she did not see the suicidal ideation diagnosis, or the progress note of an attempt. She said if she would have seen that she would have notified the department heads because the facility was possibly not the place for the resident. Interview on 08/16/24 at 12:11 PM with the MDS Nurse revealed he had created Resident #1's face sheet for the facility and copied the resident's diagnoses from the previous facility's face sheet including the diagnosis of suicidal ideation. The MDS Nurse said he did not tell anyone about the suicidal ideation because he assumed they were all aware. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 8:15 AM with the Administrator revealed Resident #1 was transferred from another nursing facility. They were not aware until after the resident's incident, 08/15/24, that the resident had been given a 30-day discharge notice. After the resident arrived, she started to want a lot of one-on-one attention from the staff. On Wednesday, 08/14/24, Resident #1 began to complain of stomach issues and after she had been given medication, the resident then escalated her stomach symptoms to saying she had chest pains. Resident #1 was assessed, and her vitals were within normal range but she was sent to the hospital and returned shortly with no new orders. The Administrator said Resident #1 was making statements the morning of 08/15/24 saying everyone hated her and she was going to get kicked out of the facility. Resident #1 later went to the nurse's station and told staff she had drank hand sanitizer from a pocket size bottle she was holding stating she wanted to kill herself. There appeared to be some on her shirt, so they were not aware how much she had consumed so they called 911 and she was transferred out for evaluation. The Administrator further stated she had seen the suicidal ideation on the face sheet before Resident #1 has been admitted but she did not know how long ago it had taken place and when she had reviewed the referral she had not read anything recent that implied the resident had attempted suicide. No one was asked about her past and they were just going off of what was in the recent notes. After administrative review, an Immediate Jeopardy was identified on 08/29/24. The Administrator was notified of the Immediate Jeopardy on 08/29/24 4:31 PM. The IJ template was provided to the facility on [DATE] at 4:31 PM. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 08/17/24 at 9:50 AM and reflected the following: F600 Abuse and Neglect The facility failed to ensure a resident had the right to be free of neglect when a resident with a documented diagnosis of suicidal ideation reported that she wanted to kill herself and ingested a small amount of hand sanitizer. Interventions: 1. As of 8/16/24, Resident #1 remains in the hospital for evaluation. 2. All resident rooms were inspected by the Administrator, DON, and ADON for hazardous items that are not allowed in resident rooms as of 8/16/24. All pocket hand sanitizers have been removed from resident rooms and common areas. 3. A complete audit of active resident diagnoses in the facility was completed by the Regional Compliance Nurse on 8/16/24. 1 additional resident with a diagnosis of suicidal ideations was verified by the Regional Compliance Nurse to have a care plan with interventions as of 8/16/24. This resident is not actively suicidal. All suicidal diagnoses and care plans have been reviewed as of 8/16/24. 4. The Regional Compliance Nurse will complete a 1:1 in-service the Administrator, DON, and ADON on reviewing the diagnosis list upon admission to ensure the diagnosis and appropriate interventions are included on the baseline care plan. Completed 8/16/24. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The DON/MDS Coordinator/ designee will review all new admission records, diagnoses, and care areas daily during the morning clinical meeting to ensure that all suicidal ideation diagnoses are listed on the baseline care plan with appropriate interventions. The IDT Team will review the baseline care plan in the meeting to ensure all necessary care and services listed on the care plan have been initiated. A copy of the baseline care plan will be provided and discussed with the resident and/or RP within 48hrs. This will begin on 8/16/24 and continue indefinitely. The DON/MDS Coordinator/designee will be responsible for this process. 6. The Medical Director notified of the immediate jeopardy by the Administrator on 8/16/24. 7. An QAPI meeting was conducted with the IDT team to include the Medical Director on 8/16/24 to discuss the immediate jeopardy citation and subsequent plan of correction. In-services: 1. The Regional Compliance Nurse will in-service the Administrator, DON, and ADON 1:1 on the following topics below. The Administrator, DON, and ADON will then in-service all staff on the following topics below. All staff not present for the in-services will not be allowed to work their next shift until the in-services are complete. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming scheduled shift. a. All staff will be in-serviced by the Administrator, DON, and Regional Compliance Nurse on Abuse and Neglect on 8/16/24. b. All staff will be in-serviced by the Administrator, DON, and Regional Compliance Nurse on hazardous items that are not allowed in resident rooms including alcohol-based hand sanitizer on 8/16/24. c. All Charge Nurses will be in-serviced on baseline care plans- ensuring a diagnosis of suicidal ideations is included on the baseline care plan with appropriate interventions upon admission. In-servicing will be completed by the Regional Compliance Nurse and DON on 8/16/24. Monitoring of facility's Plan of Removal included the following: Observation on 08/17/24 from 10:35 AM to 11:20 AM of the resident rooms where residents resided on hall 100, 300, and 500 and common areas revealed there were no hazardous items observed in the room or within resident reach to include hand sanitizer. Record Review of Resident #2, who was identified as having a diagnosis of suicidal ideation revealed the resident has been assessed and there were measures in place to monitor the resident. Interviews on 08/17/24 from 11:17 AM to 2:19 PM from staff from various shifts were Administrator, Administrator in Training, DON, ADON, Social Worker, MDS Nurse, BOM, Marketer, Medical Records, Maintenance Director, Dietary Aide, Laundry Aide LVN's A, B, C and D, RNs I, J, K, CNAs E, F, G, H, MAS N, O, Housekeeping L, M. All staff were able to identify the following: - The different types of abuse. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- What do if they see a resident showing signs of distress or hear a resident verbalizing harm to themselves or stating they want to die. - What hazardous items not allowed in resident rooms and what to do if they find them. LVN's A, B, C, D and RNs I, J, K were able to explain what to do if a resident was admitted with a diagnosis of suicidal ideation. The Administrator, DON, and ADON were provided in-service to review all resident diagnoses before they are admitted and to put the proper interventions in place for each resident. After administrative review, an IJ was identified on 08/29/24. The IJ template was provided to the facility on [DATE] at 4:31 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for one of five residents (Resident #1) reviewed for baseline care plans. The facility failed to establish a base line care plan to address Resident #1's diagnosis of suicidal ideation when she admitted to the facility. On 08/15/24, Resident #1 reported to facility that she drank hand sanitizer from a small pocket-sized bottle and wanted to kill herself. An IJ was identified on 08/15/24. The IJ template was provided to the facility on [DATE] at 3:48 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure place residents at risk of not having their needs met, serious physical harm, injury, and/or death. Findings included: Review of Resident #1's face sheet printed on 08/17/24 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, major depressive disorder, post-traumatic stress disorder, adjustment disorder with anxiety, conversion disorder with sensory symptom (condition where a mental health issue causes physical symptoms), moderate intellectual disabilities, autistic disorder, and suicidal ideation. Review of Resident #1's New Referral documentation dated 07/30/24, sent from the prior nursing facility where Resident #1 resided at, reflected one of the resident's diagnoses was suicidal ideation. Further review of Resident #1's referral documentation reflected there was a progress note, dated 07/23/24 reflected: Resident is having suicidal attempts, suicidal thoughts. Sent to [Hospital] for further treatment. Notified the Legal Guardian. Review of Resident #1's baseline care plan initiated on 08/06/24 reflected Resident #1 had attention seeking behaviors as evidenced by not allowing staff to maintain professional boundaries. Resident would go into multiple staff offices with no regard with what is going on in the office such as meetings with other residents or families and attempt to talk to staff regarding resident's personal life and history for hours at a time. When staff reinforce professional boundaries resident thinks staff do not like her or are being mean to her and make allegations. Interventions included to monitor behavior episodes and attempts to determine underlying cause. Document behavior and potential causes. Further review of the baseline care plan revealed there was no diagnosis of suicide ideation. Review of a statement from the facility's Provider Investigation Report for Resident #1, dated 08/15/24, documented by the Administrator in Training reflected the following: (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At approximately 8:30 AM on 08/15/24, I was standing at the nurse's station when [Resident #1] wheeled up to me with a liquid staining on the front of the shirt. She showed me a small personal hand sanitizer bottle and said that she drank it. The bottle was approximately 1/4 full. She said that she drank it to kill herself then expressed a series of similar suicidal ideations. I immediately provided 1:1 attention to her while the nursing staff contacted emergency services. The staff offered her water and milk, but the resident refused despite prompting from multiple staff, including myself. I remained with the resident until emergency services arrived approximately 15 minutes later. Although I observed the resident expressing sadness and making weeping sounds, I did not witness any tears throughout the time period that I interacted with her. Review of Resident #1's progress notes dated 08/15/24 documented by LVN A reflected the following: Resident at nurses desk states she swallowed a bottle of hand sanitizer, Resident states she wanted to kill herself. Resident places on one on one. DON present. Resident very upset. She is alert and oriented. New order to send resident to hospital. Resident sent to [Hospital]. Her conservator notified Interview on 08/15/24 at 9:34 AM with LVN A revealed Resident #1 had gone to the hospital the evening before, 08/14/24, due to feeling ill and she got report from the previous charge nurse that Resident #1 had wrote on her hospital discharge paperwork, scribbled out some of her diagnoses and wrote other in. LVN A said it appeared Resident #1 became upset when she was asked why she had written on her discharge paperwork. A while later after LVN A had finished getting report from the previous charge nurse, LVN A was at the nurse's station and Resident #1 approached her, holding a small bottle of hand sanitizer and said I hope everyone is happy I just drank this. LVN A said the bottle of hand sanitizer still had about a 1/4 left inside. The DON was also at the nurse's station at the time, and they called 911 and the resident's guardian. Resident #1 was visibly upset, and she was offered milk which she refused, and she was monitored until she was transferred to the hospital. LVN A further stated Resident #1 sought out attention from the staff, would report one ailment after another and if they took too long to respond, Resident #1 would begin to say people did not like her and she was going to be kicked out of the facility. LVN A further stated Resident #1 had not expressed any suicidal ideations prior to the incident on 08/15/24. Interview on 08/16/24 at 11:15 AM with the Administrator in Training revealed he was at the nurse's station the day of the incident, 08/15/24, and heard Resident #1 call for him and wheeled towards him very quickly. The front of Resident #1's shirt looked like she had vomited or spit something out of her mouth, she held up a small, pocket size bottle of hand sanitizer and stated she had drank it and wanted to die. The bottle of sanitizer appeared to have about a quarter left inside. LVN A and the DON were also at the nurse's station when the incident occurred and they stayed with the resident 1:1 until 911 was contacted. While they waited for EMS to arrive, Resident #1 continued to say she wanted to die even if she went to hell because no one loved her, and she did not belong in heaven. Resident #1 was transferred to the hospital for further evaluation. The Administrator in Training said he had a lot of contact with Resident #1 prior to the incident and said the resident did not respect boundaries and made her way into staff offices, even if they were with other residents or families. When the resident would be reminded of the boundaries, she would become upset stating no one loved her even when they would try to reassure her. The Administrator in Training further stated Resident #1's moods were very unpredictable and described them as lows and highs but the resident had never expressed suicidal ideations. (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 10:08 AM with the Social Worker revealed Resident #1 had attention seeking behaviors and did not have a lot of boundaries towards others. She said the resident was upbeat for the most part and had never expressed suicidal ideations during her stay. The day of the incident, 08/15/24, Resident #1 had already handed the sanitizer to the nursing staff and she was being monitored until the resident was transferred to hospital. The Social Worker stated she was not aware the resident has a diagnosis of suicidal ideations and had she seen that on the face sheet, that would have been a red flag to look into the matter further to put appropriate measure in place. The Social Worker said Resident #1 had a guardian that had been appointed to her in April 2024, who told her after the incident, that Resident #1 had previously tried to drink mouthwash and swallowed a keychain in an attempt to harm herself. Interview on 08/16/24 at 10:54 AM with Resident #1's guardian revealed she had taken over as legal guardian for Resident #1 in April 2024, because her family could no longer do it. She said shortly after either late April or early May, Resident #1 had expressed suicidal ideations and had drank mouthwash and swallowed a keychain. The resident was transferred to the hospital where they had to do an endoscopy to remove the keychain. While Resident #1 was at the previous facility, she continuously called 911 wanting to be taken to the emergency room for various reasons. The resident was given a 30-day discharge notice from the previous facility and when she was transferred to the current facility, she forgot to tell the facility about the mouthwash and keychain incident because there were so many things going on with Resident #1's behaviors. Interview on 08/16/24 at 11:26 AM with the DON revealed after Resident #1 was admitted she began to make accusations against staff stating they did not like her. The resident was attention seeking and would enter staff offices even if they were busy with other staff or residents wanting to talk about her childhood life. The day of the incident, 08/15/24, Resident #1 was at the nurse's station, upset, stating no one liked her because she had been questioned about writing on her hospital discharge paperwork from the day prior. Resident #1 had scribbled out some of her diagnoses and handwritten others and when she was questioned about it, she became upset, cried and rolled away from the nurse's station. The DON said Resident #1 returned back to the nurse's station holding a pocket size hand sanitizer and said she had drank it because she wanted to die. The resident made the statement that she had googled if she drank enough of the hand sanitizer it would kill her that she has in her personal belongings. They immediately called 911 as the resident continued to say she wanted to die. Initially Resident #1 refused to go to the hospital but eventually was transferred out. The DON further stated new admission paperwork was reviewed by the Administrator, the ADON and herself and she did not see the diagnosis of suicidal ideations or read the note where Resident #1 had suicide attempts. The DON said if she would have seen that, she probably would have recommended Resident #1 to a psychiatric facility instead of admitting her to their facility. Interview on 08/16/24 at 11:40 AM with the ADON revealed Resident #1 was very talkative and was attention seeking. As the days went by, the attention seeking escalated and the resident would go around asking for hugs and kisses, asking people if they liked her. The day of the incident, 08/15/24, when she got to work, Resident #1 was at the nurse's station and there were a couple of staff around the resident and she had already drank the hand sanitizer. Resident #1 continued to state no one liked her. The ADON said she had read Resident #1's referral before she was admitted, and the documentation had not painted the real picture of who the resident really was. The ADON further stated she did not see the suicidal ideation diagnosis, or the progress note of an attempt. She said if she would have seen that she would have notified the department heads because the facility was possibly not the place for the resident. (continued on next page)		

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/16/24 at 12:11 PM with the MDS Nurse revealed he had created Resident #1's face sheet and copied the resident's diagnoses from the previous facility's face sheet including the diagnosis of suicidal ideation. The MDS Nurse said he did not tell anyone about the suicidal ideation because he assumed they were all aware. The MDS nurse further stated RNs were responsible for creating the baseline care plans. Interview on 08/16/24 at 12:27 PM with RN K revealed she had initiated Resident #1's care plan based on her initial assessment. RN K said she never saw the suicidal ideation diagnosis on the resident's face sheet. RN K further stated if she would have seen that diagnosis, she would have made nursing management aware so they could have put precautions in place. Interview on 08/16/24 at 8:15 AM with the Administrator revealed Resident #1 was transferred from another nursing facility. They were not aware until after the resident's incident, 08/15/24, that the resident had been given a 30-day discharge notice. After the resident arrived, she started to want a lot of one-on-one attention from the staff. On Wednesday, 08/14/24, Resident #1 began to complain of stomach issues and after she had been given medication, the resident then escalated her stomach symptoms to saying she had chest pains. Resident #1 was assessed, and her vitals were within normal range but she was sent to the hospital and returned shortly with no new orders. The Administrator said Resident #1 was making statements the morning of 08/15/24 saying everyone hated her and she was going to get kicked out of the facility. Resident #1 later went to the nurse's station and told staff she had drank hand sanitizer from a pocket size bottle she was holding stating she wanted to kill herself. There appeared to be some on her shirt, so they were not aware how much she had consumed so they called 911 and she was transferred out for evaluation. The Administrator further stated she had seen the suicidal ideation on the face sheet before Resident #1 has been admitted but she did not know how long ago it had taken place and when she had reviewed the referral she had not read anything recent that implied the resident had attempted suicide. No one was asked about her past and they were just going off of what was in the recent notes. Review of the facility's undated policy titled Base Line Care Plans reflected the following: Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care An Immediate Jeopardy was identified on 08/16/24. The Administrator and the Regional RN were notified of the Immediate Jeopardy on 08/16/24 at 3:33 PM. The IJ template was provided to the facility on [DATE] at 3:48 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 08/17/24 at 9:50 AM and reflected the following: F655 Baseline Care Plan (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2024
NAME OF PROVIDER OR SUPPLIER North Pointe Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7804 Virgil Anthony Blvd Watauga, TX 76148	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to develop a baseline care plan for a resident, who admitted with a documented diagnosis of suicidal ideation. Interventions: 8. As of 8/16/24, Resident #1 remains in the hospital for evaluation. 9. A complete audit of active resident diagnoses in the facility was completed by the Regional Compliance Nurse on 8/16/24. 1 additional resident with a diagnosis of suicidal ideations was verified by the Regional Compliance Nurse to have a care plan with interventions as of 8/16/24. All suicidal diagnoses and care plans have been reviewed as of 8/16/24. 10. The Regional Compliance Nurse will complete a 1:1 in-service the Administrator, DON, and ADON on reviewing the diagnosis list upon admission to ensure the diagnosis and appropriate interventions are included on the baseline care plan. Completed 8/16/24. 11. The DON/MDS Coordinator/ designee will review all new admission records, diagnoses, and care areas daily during the morning clinical meeting to ensure that all suicidal ideation diagnoses are listed on the baseline care plan with appropriate interventions. The IDT Team will review the baseline care plan in the meeting to ensure all necessary care and services listed on the care plan have been initiated. A copy of the baseline care plan will be provided and discussed with the resident and/or RP within 48hrs. This will begin on 8/16/24 and continue indefinitely. The DON/MDS Coordinator/designee will be responsible for this process. 12. The Medical Director notified of the immediate jeopardy by the Administrator on 8/16/24. 13. An ADHOC QAPI meeting was conducted with the IDT team to include the Medical Director on 8/16/24 to discuss the immediate jeopardy citation and subsequent plan of correction. In-services: 2. The Regional Compliance Nurse will in-service the Administrator, DON, and ADON 1:1 on the following topic below. The Administrator, DON, and ADON will then in-service all staff on the following topic below. All staff not present for the in-services will not be allowed to work their next shift until the in-services are complete. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming scheduled shift. a. All Charge Nurses will be in-serviced on baseline care plans- ensuring a diagnosis of suicidal ideations is included on the baseline care plan with appropriate interventions upon admission. In-servicing will be completed by the Regional Compliance Nurse and DON on 8/16/24. Monitoring of facility's Plan of Removal included the following: Record Review of Resident #2, who was identified as having a diagnosis of suicidal ideation revealed the resident has been assessed and there were measures in place to monitor the resident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2024
NAME OF PROVIDER OR SUPPLIER North Pointe Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7804 Virgil Anthony Blvd Watauga, TX 76148	
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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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 08/17/24 from 11:17 AM to 2:19 PM from staff from various shifts were Administrator, Administrator in Training, DON, ADON, Social Worker, MDS Nurse, BOM, Marketer, Medical Records, Maintenance Director, Dietary Aide, Laundry Aide LVN's A, B, C and D, RNs I, J, K, CNAs E, F, G, H, MAs N, O, Housekeeping L, M. All staff were able to identify the following: - What do if they see a resident showing signs of distress or hear a resident verbalizing harm to themselves or stating they want to die. LVN's A, B, C , D and RNs I, J, K were able to explain what to do if a resident is admitted with a diagnosis of suicidal ideation. The Administrator, DON, and ADON were provided in-service to review all resident diagnoses before they are admitted and to put the proper interventions in place for each resident. An IJ was identified on 08/15/24. The IJ template was provided to the facility on [DATE] at 3:48 PM. While the IJ was removed on 08/16/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.		