

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/25/2025
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 - Minimal harm or potential for actual harm 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** 43791 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, or misappropriation of resident property for 1 of 3 residents (Resident #1) reviewed for abuse. CNA A was witnessed to have spoken in a verbally abusive manner about Resident #1 This failure could cause residents to have decreased feelings of self-worth. The noncompliance was identified as past noncompliance that began on 07/10/24 and ended on 07/10/24. The facility had corrected the noncompliance before the state surveyor entered. No plan of correction needed. Findings included: Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting the left side of her body, diabetes, morbid obesity, and need for assistance with personal care. Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 14, indicating she was cognitively intact. Her Functional Assessment indicated she was totally dependent on staff for all of her ADLs except eating. Record review of Resident #1's care plan, dated 12/30/24, reflected she had left sided paralysis related to her stroke, with interventions to assist with ADLs and mobility as needed. She was at risk for pressure ulcers related to her paralysis and obesity, with interventions of repositioning as needed, and using a pressure relieving mattress. Resident #1 had bowel and bladder incontinence related to paralysis, with interventions of providing incontinence care as needed. Record review on 02/25/25 at 8:30 AM of a video submitted by Resident #1's family member, dated 07/10/24, revealed CNA A can be observed walking away from Resident #1 to the doorway of the room and talking very loudly to someone in the hallway, saying If somebody don't come in here with me, right hand to God. She keeps pushing back on my hand and I already got a bad hand [NAME]. She gonna make me flip her ass out of this bed. She's gonna piss me off. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the BOM's undated written statement reflected: On 7/10/24 around lunch time I was in my office when I heard some yelling in the hallway. Through my door I witnessed [CNA A] saying It's really pissing me off. I swear on everything, someone come help me cause she about to make me flip her ass out of the bed. Upon hearing this, I immediately exited my office and confronted [CNA A] in the hall. I told her she did not need to speak that way or say those things ever. She voiced her frustration about struggling to change the resident independently. I told her I understood but her behavior and verbiage was unacceptable and not tolerated and that she needed to calm down and ask for a patient change or some assistance from another CNA. After this conversation I immediately notified [the DON] and [Administrator] of what occurred in the hallway and the conversation that took place. Record review of CNA B's written statement, dated 07/11/24, reflected: So on 7.10.24 about 11:45 am I witnessed [CNA A] come out into the hall asking for help, she seemed agitated so I asked her what was wrong when she started to explain she was a little loud but she talks loud normally, so she stated can you come help with [Resident #1] before she make me flip her out the bed. She did not mean it in a way like intentional, she meant it accidentally because [Resident #1] do push back while trying to change her, she stated her wrist was hurting and that she needed help. I never witnessed her being verbally abusive towards [Resident #1], only the fact she was loud but it was not in [Resident #1's] room she was out in the hall talking to me. Record review of the facility's Provider Investigation Report, completed by the Administrator on 07/17/24, reflected Resident #1's family member called the DON to report that she had viewed on the camera in Resident #1's room, a CNA cursing, using profanity, and arguing with Resident #1 while providing the resident with care. Following the report, Resident #1 was assessed and found to have no mental anguish or injuries. The report reflected CNA A was suspended pending investigation, staff were re-educated on abuse and neglect, and safe surveys were completed. The report further reflected: Upon review of video footage provided by resident's [family member], it was determined that [CNA A] did not act professionally. She was observed standing in [the] doorway of [the] residents [sic] room talking loudly into [the] hallway. [CNA A] stated 'somebody gotta come in here with me, right hand of God. She keeps pushing back on my hand. I already have a bad hand [NAME]. She gonna make me flip her ass out this bed. She gonna piss me off.' She was not speaking directly to [the] resident but was in ear shot of [the] resident. The report concluded with facility terminating CNA A's employment. Record review of the Inservice Training Report, dated 07/10/24, reflected facility staff were trained by the Administrator on Abuse and Neglect. Record review of Safe Surveys completed following the incident reflected no residents complained of abuse. Record review of the facility's Employee Disciplinary Report, dated 07/12/24, reflected CNA A's employment was terminated due to allegations of her verbally abusing a resident being substantiated. The report reflected: [CNA A's] actions were in violation of the Corporate Code of Conduct by violating the Resident's Rights and failing to carry out her duties/responsibilities and or performing work of substandard quality/quantity. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview attempts on 02/25/25 at 9:00 AM and 1:55 PM with CNA A were unsuccessful. The message on CNA A's phone service reflected she was not taking phone calls at this time and did not allow for a voicemail message to be left. Interview on 02/25/25 at 9:10 AM with Resident #1 revealed she recalled the event. She stated she did not remember why CNA A was mad at her, but she stated when she overheard the CNA yelling in the hallway she was very upset. She stated CNA A was always yelling at her, saying the resident was going to have to do things the CNA's way. Resident #1 stated she was embarrassed and upset about the situation. Interview on 02/25/25 at 1:30 PM with CNA B revealed she verified her written statement taken during the facility investigation was true and accurate. CNA B stated Resident #1 could be difficult to work with. When she was turned to the left, instead of grabbing onto her bed rail and pulling, she would use it to push back against the caregivers. As a result, Resident #1 was now a two person assist for incontinence care. CNA B stated residents could be embarrassed by that kind of behavior. CNA B stated she had been in-serviced by the DON immediately after the incident on abuse and neglect. She was able to identify several types of abuse, and who to notify if she witnessed any abuse. Interview on 02/25/25 at 1:43 PM with the BOM revealed she verified her written statement taken during the facility's investigation was true and accurate. The BOM stated she was in her office at the end of the 200 Hall with the door closed when she heard a loud voice in the hallway. She stepped out and observed CNA A talking very loudly and inappropriately. The BOM stated she calmed CNA A down, after she determine what CNA A was upset about she told CNA A her language was inappropriate in a professional setting, especially when residents could hear her. The BOM notified the Administrator, and turned the situation over to her. The BOM stated she had been included in the in-service conducted by the DON immediately after the incident on abuse and neglect. She was able to verbalized several types of abuse and that she wasto notify the Administrator if she witnessed any abuse. Interview on 02/25/25 at 2:58 PM with the Administrator revealed CNA A was suspended immediately until an investigation could be completed. The Administrator stated she contacted the resident's family, and the family member of Resident #1 advised she had video footage of the incident. After reviewing the video footage and conducting interviews with staff, the Administrator terminated CNA A. The Administrator stated all residents deserve to be treated with respect and dignity, any form of abuse would not be tolerated. She stated this behavior could affect residents emotional health by causing them embarrassment. The Administrator stated the DON had immediately in-serviced staff on abuse and neglect. The Social Worker conducted Safety Surveys with residents of the hall, residents reported feeling safe with staff. Record review of the facility's Abuse/Neglect policy, revised 09/09/24, reflected: .Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. .3. Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability		