STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675963	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Nursing and Rehabilitation	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 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** Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when Resident #2 physically assaulted her on 04/29/25 in Resident #3's room. The noncompliance was identified as PNC. The IJ began on 04/29/25 and ended on 05/05/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for abuse. Findings included: Record review of Resident #1's admission record, dated 06/26/25, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #1's Annual MDS Assessment, dated 03/17/25, reflected she had a BIMS of 03, indicating severe cognitive impairment. Her active diagnoses included non-traumatic brain dysfunction (refers to brain damage caused by factors other than external trauma), non-alzheimer's dementia (loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities), anxiety disorder (a mental health condition characterized by excessive fear or anxiety that interferes with daily activities), and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #1's care plan reflected the following: Focus: [Resident #1] has a potential psychosocial well-being problem r/t potential altercation with another resident .Interventions: Monitor/document residents feelings relative to (i.e [sic] isolation, unhappiness, anger). Date Initiated: 04/29/25 .Skin assessment, Pain assessment, Trauma Informed Care, MD and RP notified .The resident needs assistance/encouragement/support to identify precipitating factors, and stressors . Record review of Resident #1's Trauma Informed PRN Assessment, dated 04/29/25, reflected there was no indication the resident had recalled the situation. (continued on next page)

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	Record review of Resident #1's Weekly Skin Assessment, dated 04/29/25, reflected she had a bruise and laceration, but it did not specify any additional details. Record review of Resident #1's Weekly Skin Assessment, dated 05/06/25, reflected she had a bruise described as: Right forearm: bruising to the dorsal aspect measuring 5.5 cm x 4.5 cm; Adjacent Bruising lateral to the first, measuring 2.5 cm x 3.5 cm; Bruising to right lateral forearm, measuring 3 cm x 2.5 cm; Right hand: Bruising near the base of the thumb, lateral aspect,.08 cm [sic] x .2 cm; Bruising to dorsum of hand 3.5 cm x 2.5 cm; Left arm: Bruising near the elbow, 3.5 cm x 2.5 cm; Left hand: Bruise measuring 0.7 cm x 0.1 cm; Right lower extremity: Bruising to the right shin, 3.5 cm x 2.5 cm, Bruising to right knee, measuring 6 cm x 3 cm and a laceration described as: Laceration to the right shin, measuring 1 cm x 0.8 cm x .1 cm. Record review of Resident #1's x-ray report, dated 04/29/25, reflected there was no evidence of a fracture or dislocation. Record review of Resident #1's Progress Notes reflected the following: - On 04/29/25 at 4:00 PM, the WCN wrote: Weekly Skin Assessment .Bruise present: Yes. Location, measurements of bruising: Right forearm: bruising to the dorsal aspect measuring 5.5 cm x 4.5 cm; Adjacent Bruising lateral to the first, measuring 2.5 cm x 3.5 cm; Bruising to right lateral forearm, measuring 3 cm x 2.5 cm; Right hand: Bruising near the base of the thumb, lateral aspect,.08 cm [sic] x .2 cm; Bruising to dorsum of hand 3.5 cm x 2.5 cm; Left arm: Bruising near the elbow, 3.5 cm x 2.5 cm; Left hand: Bruise measuring 0.7 cm x 0.1 cm; Right lower extremity: Bruising to the right shin, 3.5 cm x 2.5 cm, Bruising to right knee, measuring 6 cm x 3 cm and Laceration is 0.6 cm x 0.6 cm .Laceration present: Yes. Location, measurements of laceration: Right hand: dorsum of hand, a pinpoint opening noted within the contusion. Left arm, Left temple: Laceration present, measuring 3 cm x 2 cm. Left hand, Right lower extremity: Laceration to the right shin, measuring 1 cm x 0.6 cm. Laceration to right knee, measuring 0.6 cm x 0.6 cm . - On 04/29/25 at 7:58 PM, the WCN wrote: Skin assessment completed. Multiple contusions and lacerations noted: .Contusion and laceration to the right shin, measuring 3.5 cm x 2.5 cm, with an open area within the contusion measuring 1 cm x 0.6 cm. Contusion and Laceration [sic] to right knee, measuring 6 cm x 3 cm and Laceration [sic] is 0.6 cm x 0.6 cm .Patient tolerated assessment without complaints. Wounds to be monitored per protocol. - On 04/29/25 at 7:59 PM, the WCN wrote: Injury Follow-Up .Swelling Present, Painful, Pain appear to be present: Yes Location [sic] of resident pain: right knee and shin Pain [sic] is described as: unable to specify due to dementia Pain [sic] relieving interventions: Tylenol as ordered .Interventions: .The assailant was removed from the building immediately . - On 04/29/25 at 9:31 PM, RN A wrote: Resident was in another resident's room when staff entered the room and observed other resident holding a footrest to a wheelchair in his hand. Upon seeing staff, he immediately dropped the footrest to the floor. [Resident #1] was noted to have a small amount of blood to her left forehead, lacerations to right knee and shin, three raised red areas to right forearm and two raised red areas to left forearm. Resident was immediately removed from room and assessed by nurse. The other resident was removed from room and placed on 1 on 1 monitoring until transported to local hospital. MD and family notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 04/29/25 at 9:44 AM, RN A wrote: .Resident has multiple lacerations with small amount of blood coming out on her legs , [sic] knees, left side of the head, some bumps in her hands . - On 04/30/25 at 12:54 AM, LVN B wrote: xray [sic] results received sent to [Physician C] and poa notified no fracture [sic] or dislocation noted. -On 05/02/25 at 6:10 PM, the SW wrote: Resident is doing well. No distress over incident with another resident earlier this week. No recollection of incident at all. Observation and attempted interview on 06/26/25 at 9:21 AM with Resident #1 revealed she was in her room eating breakfast. Resident #1 did not have any signs of injuries to her that could be seen. Resident #1 said no one had ever tried to hurt or hit her. Resident #1 said she felt safe in the facility. Record review of Resident #2's face sheet, dated 06/26/25, reflected an [AGE] year-old male who originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on 05/05/25. Record review of Resident #2's MDS Assessment, dated 05/05/25, reflected a BIMS score was not calculated. His MDS indicated he had physical behavioral symptoms directed towards others and other behavioral symptoms not directed toward others. His active diagnoses included unspecified dementia (loss of cognitive functioning, including memory, language, and problem-solving abilities, that is severe enough to interfere with daily life) and recurrent depressive disorder (a mental health condition characterized by repeated episodes of deep sadness, hopelessness, and loss of interest in daily activities). Record review of Resident #2's care plan reflected the following: Focus: [Resident #2] has potential to demonstrate physical behaviors due to Dementia, Date Initiated: 04/29/25 .Interventions: 1:1 monitoring, Skin assessment, Psych follow up, Med review w/ med [sic] adjustment, MD and NP notified .If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately .Notify the charge nurse of any physically abusive behaviors .When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #2's Progress Notes reflected the following: - On 04/09/25 at 5:43 AM, LVN D wrote: Resident is very combative; he refuses to go to bed and wanders in other residents 'rooms. [sic] this nurse has redirected him multiple times but resident refuses to listen and try to fight. - On 04/10/25 at 11:44 AM, LVN E wrote: res [sic] in dining room stealing residents belongings. staff [sic] tried to get belongings back and res became very agitated with staff and hit one staff member and bit the nurse on the forearm. staff [sic] trying to explain that he cant [sic] be taking stuff from other residents. will [sic] cont to monitor resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 04/19/25 at 3:31 PM, the WCN wrote: Behavioral Incident: At approximately [9:00 AM], [Resident #2] exited his room without wearing pants or undergarments, exposing his genitalia in a public area. When nursing staff approached to redirect him to his room for redressing, he became combative and attempted to fight staff. Staff ensured safety precautions were followed during redirection. At approximately [2:30 PM], [Resident #2] began to remove his pants and exposed his genitals while walking toward the dining room. Staff promptly intervened, redirected him to his room, and assisted with redressing. Currently, [Resident #2] is ambulating in the 300 Hall. He is no longer exhibiting irate behavior but continues towander [sic]. Staff will continue to monitor closely for safety and further behavioral concerns. - On 04/24/25 at 9:32 PM, LVN E wrote: combative [sic] with staff and refused to shower or let aide help him toilet . - On 04/25/25 at 3:36 PM, the SW wrote: Call placed to [Resident #2's RP] to inform him that we needed to seek alternate placement for resident due to combative behaviors with staff and wandering in to other res rooms. [Resident #2's RP] verbalized understanding and agreement . - On 04/29/25 at 5:24 PM, LVN E wrote: [Resident #2] was observed by staff member in another resident's room sitting in his wheelchair holding a foot rest [sic] to a wheelchair in the air. When this writer walked in the room, [Resident #2] dropped the foot rest [sic] on floor [sic]. The other resident was observed with blood noted to left side of forehead and right shin and two raised red areas to right forearm. The other resident was immediately removed from the room and was assessed by nurse. [Resident #2] was placed on 1 on 1 monitoring. Family, police and EMS were called and resident was transported to hospital [sic] via police accompanied by [Resident #2's family]. - On 04/29/25 at 7:07 PM, LVN E wrote: [Resident #2] was transferred to a hospital on [DATE] at 3:00 PM related to police came and escorted resident to [Hospital Name] to evaluation and treatment [sic]. - On 04/30/25 at 12:15 AM, LVN F wrote: res back to facility via EMS Transportation [sic], received new orders from the hospital to start amoxicillin 500mg [sic] tablet, to be given orally twice daily x10 days and azithromycin 250 mg tablet to be taken as directed for pneumonia. res [sic] assessed, he is awake and alert and able to answer questions in a coherent manner. he [sic] doesn't appear in distress, helped put to bed, no skin issues head to toe assessment done. family [sic], administrator and md notified or res return. - On 04/30/25 at 3:00 AM, LVN F wrote: .attempts to calm him down to no effect as he fights and is combative trying to hit staff who are helpinghim [sic] with wheelchair foot pedals . - On 05/05/25 at 2:10 PM, LVN G wrote: Pt left facility at 210pm [sic]. discharged to [NF Name, Address, and Phone Number]. Left with all belongings including medication and clothing. Sent via transport with family by side. (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 06/26/25 at 1:19 PM with LVN I who said she recalled Resident #2 having behaviors because he had bit her one time. LVN I said she also saw Resident #2 hit a staff member as well. LVN I said Resident #2 had a behavior or stealing items from other residents and staff tried to prevent him from doing that but he would swing and kick at staff when they tried to redirect him. LVN I said she did not know about the altercation that happened between Residents #1 and #2. LVN I said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 1:41 PM with CNA J who said she recalled Resident #2 being very aggressive because he would fight the staff. CNA J said Resident #2 would get made at staff when they tried to redirect him. CNA J she knew of the incident that occurred between Residents #1 and #2 but she never saw Resident #1's injuries. CNA J said she only knew that because of Resident #1's injuries the day after it happened, she had to keep her in bed. CNA J said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 1:55 PM with MA K who said he recalled Resident #2 lived here briefly but had already left. MA K said Resident #2 had behaviors where he displayed anger and got mad and would throw things and was very agitated. MA K said he did not know what happened between Residents #1 and #2. MA K said he had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 1:57 PM with CNA L who said she could not recall Resident #2 and did not know about what happened between Residents #1 and #2. CNA L said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 2:09 PM with LVN G who said she had cared for Resident #2 one time, and he hit her once on her hand when she was trying to redirect him. LVN G said Resident #2 had a habit of going to other residents' rooms and taking their items. LVN G said she had to redirect Resident #2 often. LVN G said she did not know about what happened between Residents #1 and #2. LVN G said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 2:38 PM with CNA M who said she had cared for Resident #2, and he refused all care and would never let anyone touch him. CNA M said Resident #2 would also curse staff out in Spanish and would put furniture in front of his door on the inside so staff could not enter his room. CNA M said she saw Resident #1 after the incident with Resident #2 and said she was beaten with some sort of stick. CNA M said Resident #1 was bleeding badly, her head was swollen, her knee was bleeding, and her arms had bruises on them. CNA M said Resident #1 did not recall what happened to her. CNA M said from what she understood, a different CNA saw the incident happen between Residents #1 and #2 so the nurse on duty was alerted and the administrator was informed. CNA M said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of witness statement completed by CNA H, dated 04/29/25, reflected the following: On April 29th I was walking the hall after arriving for my shift I [sic] noticed that [Resident #3] room [sic] door was closed was shut [sic] that is why I proceeded to open it that is [sic] when I seen [sic] that [Resident #2] was in [Resident #3's] rom and was holding the wheelchair foot rest [sic] in his hand in the air while aggressively talking to [Resident #1] while she was just sitting there that is [sic] when I entered the room and asked [Resident #1] if she was okay and if [Resident #2] hit her she said [sic] that he hit her on her hand, knee, leg and the side of her face head [sic] so I proceeded to remove [Resident #1] from the room on to the front of the door away from [Resident #2] and called the nurse over and explain [sic] what I witness [sic] and showed her that [Resident #1] was bleeding. Interview on 06/26/25 at 2:49 PM on the phone with CNA H revealed she no longer worked at the facility and could not say what actually happened between Residents #1 and #2. CNA H said that she was walking down the hall and noticed Resident #3's door was closed but she was a fall risk, so she went to open the door and noticed Resident #1 in the room with Resident #2. CNA H said she walked into the room and noticed Resident #2 had a footrest from a wheelchair in his hand and he was waving it towards Resident #1. CNA H said she immediately separated the residents and took Resident #1 out of the room, asked her if she was okay, and Resident #1 told her no, he hit me. CNA H said once she got to the hallway with Resident #1, she faced towards the resident and noticed she was bleeding, had contusions to her head, knee, and foot. CNA H said she took Resident #1 to the nurse's station and told the nurse on duty what had happened. CNA H said she then tried to get Resident #2 out of Resident #3's room but he had a behavior of being aggressive towards staff. CNA H said she tried to reorient and redirect Resident #2 and started to remove him from the situation and talk to him afterwards. CNA H said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/26/25 at 2:53 PM with CNA N who said she did not know about the situation that happened between Residents #1 and #2. CNA N said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Record review of a witness statement completed by LVN E, dated 04/29/25, reflected the following: Writer was called in room [sic] by staff. [Resident #2] was in another resident's room. When writer walked in he was holding a foot rest [sic] in L hand [sic] and dropped it. Another female resident was noted with injuries when asked what occurred 'stated, he hit her' [sic]. He was asked to leave the room and refused, stayed one-on-one with resident until he exited room. Interview on 06/26/25 at 3:03 PM with LVN E who said she was told by the aide who came to get her that Resident #1 was found near Resident #3's bed bleeding. LVN E said the aide told her that Resident #2 was also in the room and had something in his hand and he dropped it. LVN E said when she assessed Resident #1, she was bleeding from her head and leg, so she provided first aide. LVN E said Resident #2 had behaviors of lashing out towards staff verbally, did not want to take his medications, and had a habit of going to other rooms and taking their items. LVN E said staff tried to redirect Resident #2 and keep him as busy as possible, but it was hard to focus on just one resident at all times. LVN E said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. (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 06/26/25 at 3:14 PM with RN O who said she only heard that Resident #2 hit Resident #1 with a wheelchair footrest. RN O said Resident #2 would show behaviors of being physically aggressive and did not allow staff to care for him. RN O said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/27/25 at 11:01 AM with the SW who said Resident #2 could be short tempered and was easily agitated or aggravated. The SW said Resident #2 had a behavior of assaulting staff before this incident happened with Resident #1 but had not gone after residents that she was aware of. The SW said after the residents were separated immediately following the incident, she was told to start seeking alternate placement for Resident #2. The SW said the facility was already in the process of transferring him to another facility due to his behaviors with staff because it made it hard to care for him. The SW said the facility requested Resident #2's family to also come and sit with him to help manage his behaviors as he was also placed on one-to-one until he discharged to a different facility. The SW said Resident #2 was also moved down the hall where he kept wandering towards because he was convinced that was where his room was. The SW said she talked to Resident #1 who was a poor historian and could not recall what had happened to her. Interview on 06/27/25 at 11:48 AM with the WCN who said she completed a skin assessment on Resident #1 after the incident between her and Resident #2. The WCN said from what she remembered, Resident #1 had a gash to her temple on her right side, another gash to her lower right leg, both of which took time to get those two to stop bleeding. The WCN said Resident #1 also had contusions, 3 on her arm where she assumed the resident was trying to guard herself from the hits by Resident #2. The WCN said Resident #1 also had a few injuries to her hand as well. The WCN said she applied first aid to Resident #1 and the wound care doctor came to round on her two or three times before her injuries were healed. The WCN said Resident #1 could not remember what happened to her since she had severe dementia. The WCN said Resident #3 was in her room where all of this happened between Residents #1 and #2. The WCN said Resident #3 told her that Resident #2 had a footrest from a wheelchair that he used to hit Resident #1 with that caused the gashes to her body. The WCN said when Resident #2 first admitted to the facility he had behaviors, which the facility thought was related to his blood sugar levels being very brittle. The WCN said later on, they learned his behaviors were not related to his blood sugar levels. The WCN said Resident #2 seemed to be targeting women for some reason so he was placed on one-to-one and every 15 minute checks. The WCN said Resident #2 often went down the 500 hallway even though his room was not on that hall, so staff had to redirect him back to his own room. The WCN said Resident #2 was a very strong guy and the facility could not figure out what his triggers were. The WCN said Resident #2 never harmed other residents that she knew of but was physically aggressive with staff. The WCN said she had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. (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 06/27/25 at 11:58 AM with the ADON revealed she was told that Resident #2 was in a room on the 500 hallway which was not his hall but he was fixated on that hall for some reason. The ADON said Resident #1 was in Resident #3's room visiting when Resident #2 entered. The ADON said a CNA was walking down the hallway and saw Resident #3's door closed which was unusual so she opened it and saw Resident #2 with a footrest in his hand and Resident #1 did not look like herself. The ADON said she saw the skin tears to Resident #1 and put two and two together. The ADON said the CNA separated the two residents and brought Resident #1 to the nurse's station so she could be assessed. The ADON said the facility also ordered x-rays, notified the doctor, and got psych involved as well. The ADON said the facility began to look for alternate placement for Resident #2, but in the meantime, he was placed on one-on-one and every 15-minute checks until he discharged . The ADON said Resident #1's injuries included skin tears to her knuckles, a laceration to her forehead on the left side by her ear, injuries to her arms with a couple of skin tears, and a laceration to her right shin. The ADON said Resident #1 was not able to say what had happened to her. The ADON said it happened in Resident #3's room but when asked, she only stated she had stayed out of it. The ADON said that Resident #3 seemed to be confused, thinking that what was happening was a domestic dispute between a couple. The ADON said Resident #2 had behaviors that included thinking other resident items were his. The ADON said once he thought an item was his he would begin to go after it, even if it was in another resident's room. The ADON said staff tried to redirect him but it happened often. The ADON said she and other staff had been in-serviced and knew what to do regarding abuse, resident-to-resident altercations, and de-escalation techniques. Interview on 06/27/25 at 12:16 PM with the Administrator revealed the facility did not currently have a DON at the facility. The Administrator said it was reported to her that a CNA walked in and Residents #1 and #2 were in Resident #3's room. The Administrator said Resident #3 was in her bed and Resident #2 was holding a footrest up in the air yelling. The Administrator said Resident #1 was taken out of the room and had scratches or a laceration on the side of her temporal, redness on her arms and scratches, and some injury on her knee. The Administrator said Resident #2 was immediately placed on one-to-one and the facility began searching for somewhere else to send him. The Administrator said Resident #1 was not able to say what had happened to her, and neither could Resident #3. The Administrator said Resident #2 had verbal behaviors because he would curse staff out often, but he never hit another resident that she knew of. The Administrator said staff would see Resident #2 escalating in the dining room so staff would move him away and he would calm down. The Administrator said Resident #2 would also fight staff while receiving care. The Administrator said after the incident occurred, all staff were in-serviced regarding de-escalation techniques, abuse, and resident-to-resident altercations. The Administrator said anytime someone was assaulted, that would be considered abuse. The Administrator said in the situation involving Residents #1 and #2, Resident #2 had physically abused Resident #1. The Administrator said all staff had been trained to identify abuse and intervene beforehand. The Administrator said all residents had the right to be free from abuse and all staff were responsible for providing that right for them. The Administrator said anything could happen if a resident was not free from abuse, including injury or emotional trauma. The Administrator said all staff should be making rounds, assessing residents, and checking for any sign or symptom of abuse. Record review of the facility's Provider Investigation Report reflected the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675963	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Nursing and Rehabilitation	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	Provider Response: [Resident #1] was immediately removed from room and assesses [sic] and treated by nurse. [Resident #2] was placed on 1 on 1 monitoring. Administrator obtained witness statements from staff and residents. MD, family, and EMS/Police notified. Social Worker completed trauma informed assessment on all residents involved with no negative findings. Facility completed x-rays on [Resident #1] with no negative findings. [Resident #2] was sent to hospital for evaluation on 4/29/25. Resident returned to facility on 4/29/25 with new diagnosis of Pneumonia and new orders for antibiotics. Psych MD reviewed medications and added new order for Risperidone. Also, obtained order from Medical Director for Tylenol BID and order to obtain CBC, BMP and UA on [Resident #2]. Social Worker began seeking placement for [Resident #2] at alternate facilities. Staff inserviced [sic] on Abuse & Neglect/Resident to Resident Altercations-Deescalation [sic]. [Resident #1] sustained minor injuries that did not require hospital treatment .Investigation Summary: Both residents involved in incident have diagnosis of dementia. [Resident #2] denied hitting [Resident #1]. [Resident #1] and [Resident #3] stated that [Resident #2] hit [Resident #1]. However, upon reinterview on 4/30/25 with [Resident #1] and [Resident #3], neither resident could recall the incident .Facility Investigation Findings: Confirmed .Provider Action Taken Post-Investigation: .[Resident #2] was discharged to another facility with memory [sic] care unit on 5/5/25. Record review of a witness statement completed by the ADON, dated 04/29/25, reflected the following: This nurse interviewed 3 residents in regard to the resident-to-resident altercation with [Resident #2] and [Resident #1]. Please read below for all statements. [Resident #1]- 'no one has done anything to me'. When asked is she hurt she rubbed her knees and thigh on the right side .[Resident #3]- 'that man had that thing in his hand swinging it hitting that woman. No. he [sic] didn't hit me. I stayed away from him.' [Resident #3]- translator present 'I didn't do anything she was in my room.' I want her out' [sic] Resident remains on 1 on 1 supervision. Record review of five safe surveys completed with residents revealed they felt safe in the facility. Record review of an in-service record, dated 04/29/25, and titled Abuse & Neglect/Res to Res Altercations revealed 60 staff signatures indicating they had been in-serviced. Record review of the facility's Abuse/Negelct policy, revised 09/09/24, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .Resident 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 .1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The noncompliance was identified as PNC. The IJ began on 04/29/25 and ended on 05/05/25. The facility had corrected the noncompliance before the survey began.