

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 09/11/2025
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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for two of five residents (Resident #1 and Resident #2) reviewed for supervision. 1.) The facility failed to ensure Resident #1 was adequately supervised in order to prevent her from eloping from the facility. Resident #1, who was known to have confusion and wandering behaviors, first exited from an exterior door of the facility on 04/01/25. The facility failed to provide adequate supervision, and Resident #1 eloped from the facility on 09/06/25. 2.) The facility failed to ensure the Wander Guard system (an electronic system that could trigger alarms and lock monitored doors to prevent a resident from leaving unattended) utilized for Resident #2 was in proper working order. An Immediate Jeopardy (IJ) was identified on 09/10/25 at 1:50PM. The IJ template was provided to the facility on [DATE] at 2:08PM. While the IJ was removed on 09/11/25, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility still monitoring the effectiveness of their Plan of Removal. This failure placed residents at risk for not being adequately supervised and the potential for serious injury and/or death. Findings included: 1.) Record review of Resident #1's Face Sheet, dated 09/10/25, reflected she was an [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses including vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) and repeated falls (a personal history of falls). Resident #1 was discharged from the facility on 09/07/25. Record review of Resident #1's MDS Assessment, dated 07/09/25, reflected she had a BIMS score of 04, indicating she had severe cognitive impairment. She was not documented as utilizing a wandering/elopement alarm at the time of the assessment. Resident #1 was identified as being able to walk 150 feet independently. The MDS Assessment reflected she had not displayed any recent wandering behaviors. Record review of Resident #1's Care Plan, dated 07/09/25, reflected an identified focus area of being at-risk for wandering (initiation date 12/31/24, revision date 01/14/25). Goals included for Resident #1's safety to be maintained and for Resident #1 not to leave the facility unattended. Identified interventions included assessing Resident #1 for her risk of falls, distracting Resident #1 from wandering by offering pleasant diversions (structured activities, food, conversation, television, books), identifying a pattern for wandering, staying with Resident #1 and notifying the Charge Nurse if she was exit seeking, monitoring Resident #1 for fatigue and weight loss, and providing structured activities (toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes). Record review of Resident #1's Progress Notes, dated 04/01/25, reflected, .Resident disoriented but easily redirected opened door which activated the alarm. Staff immediately followed resident and walked with resident and assisted her back inside the facility. Resident stated she was searching for her car. Resident assisted back to her room. Record review of Resident #1's Elopement Risk Assessment, dated 04/01/25 (following the wandering/elopement incident), reflected she scored a 12.0, indicating she was at an increased risk for elopement. Record review of Resident #1's Elopement Risk Assessment, dated 07/02/25, reflected she scored a 20.0, indicating she was at an increased risk for elopement. Record review of an Event Report for Resident #1, dated 09/06/25, reflected, .Resident was found outside the facility after exiting through the 200 hall door. Resident was located in the front parking lot between two vehicles, on the ground. When asked, resident stated she was trying to get in her car. Assessment revealed no injuries. Resident was assisted to a standing position and ambulated back into the facility without difficulty. Record review of Resident #1's Progress Notes, dated 09/06/25 at 7:44PM, reflected, .The front and back door alarms were sounding, and staff initiated a search for residents. Resident was found outside the facility after exiting through the 200 hall door. Resident was located in the front parking lot between two vehicles, on the ground. When asked, resident stated she was trying to get in her car. Assessment revealed no injuries. Resident was assisted to a standing position and ambulated back into the facility without difficulty. Resident was redirected, and safety precautions were reinforced. Will continue to assess the resident closely for changes in condition, ensure door alarms remain functional, and notify the physician and family of the incident. Record review of Resident #1's Elopement Risk Assessment, dated 09/06/25 (following the wandering/elopement incident), reflected she scored a 26.0, indicating she was at an increased risk for elopement. Observation of the path from the exterior door on the 200 Hall to the front of the building in which Resident #1 was located (the path in which it</p>		