

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 03/08/2024
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.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 6 residents (Resident #18) reviewed for nutritional status. The facility failed to ensure Resident #18 consistently received weekly weights as prescribed by the Dietitian on 02/16/24. These failures could place residents at risk for continuing to lose weight. Findings included: Record review of a face sheet dated 03/08/24 indicated Resident #18 was a [AGE] year-old female who admitted on [DATE] with diagnoses which included vitamin deficiency, dysphagia (difficulty swallowing), and high blood pressure. Record review of a quarterly MDS dated [DATE] indicated Resident #18 BIMS score to be 99 indicating she had severe cognitive impairment. The MDS indicated Resident #18 had significant weight loss of 5% or more in a month or loss of 10% in the last 6 months. The MDS indicated Resident #18's height was 67 inches and her weight was 144 pounds. Record review of the comprehensive care plan dated 02/16/24 for Resident #18 indicated Resident #18 had a diet order other than regular and was at risk for unplanned weight loss. The care plan revealed the resident had a regular diet, mechanical soft texture, regular consistency. The intervention was to monitor her weight per facility protocol and administer a supplement with med pass. Record review of the physician's orders dated 02/16/24 indicated Resident #18 was to receive weekly weights for 4 weeks. Her orders also reflected med pass 120 mL three times a day with medications and frozen nutritional treat three times with meals. Record review of Resident #18's recorded weights indicated she weighed: 01/03/24 -162.0 pounds (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675963	Facility ID: 675963 If continuation sheet Page 1 of 11

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/09/24- 144.3 pounds 03/01/24 -140.2 pounds Record review of a Nutrition Progress Note dated 02/16/24 indicated Resident #18 had significant weight loss of 10.9% in 30 days and 10.8% in 90 days. Further review of the progress note indicated Resident #18 had fair to good intake, primarily between 25%-75%, of meals and a BMI of 22.6 and to continue to monitor. Record review of the morning and lunch meal tickets for 03/07/24 and 03/08/24 indicated Resident #18 received a Nutritional Treat (frozen nutritional supplement) with meals. Review of the March 2024 Medication Administration Record indicated Resident#18 was receiving the 120 mL med pass supplement with meals. Observation of the lunch meal service on 03/06/24 at 12:42 PM revealed Resident #18 was noted to receive a frozen nutritional supplement (magic cup) with lunch. She took all the supplement and lunch 50%. Her family member assisted with feeding. Observation of the morning meal service on 03/07/24 at 8:32 AM revealed Resident #18 received her breakfast meal. She received a frozen nutritional supplement magic cup and a cup of med pass 120 mL. Resident #18 was observed to be eating the frozen supplement and was being assisted by her family member. She ate 75%. Observation and interview on 03/08/24 at 8:32 AM with Resident #18's revealed he came everyday during breakfast and lunch, and he preferred to assist Resident#18 with feeding. He stated when he was not in the facility the facility staff assisted with feeding. He stated she does not eat much because he fed her with supplements, and he wanted her to lose weight because he brought her to facility because he could not lift her at home because of the weight. Interview with CNA B on 03/08/24 at 9:49 AM revealed Resident #18 needed assistance with feeding and when the family member was in the facility, he liked feeding her and the staff helped when he was late or not in the facility. She stated she ate around 75% of the meals, and she also got the med pass and the frozen supplements with the meals. Interview with the DON on 03/08/24 at 11:00 AM revealed the resident was noted to have lost weight, and they discussed with the family member on enrolling her on hospice since she is declining, and the husband declined. The DON stated Resident #18 is being followed by the Dietitian and was put on weekly weights which was not done .She stated once the resident was seen by Dietitian on 02/16/23 the ADON was responsible for carrying out the orders, putting the orders in the MAR and the nurses to weigh weekly. She stated the weekly weight was a recommendation from the Dietitian, but the ADON missed the orders. She stated it was her responsibility to follow up and ensure the orders were taken care of, but she did not because she was on leave. She stated failure to follow the orders could cause the resident to continue losing weight. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview/observation with MA D on 03/08/24 at 11:23 AM revealed he was observed administering 120 mL of med pass to Resident #18 and she took it all. He stated the medication aides were only responsible for the liquid Med Pass 2.0 supplement three times a day when orders appeared on their medication administration records on the screen. He said the medication aides were not responsible for the frozen nutritional supplements that came with the meals. Interview with the ADON on 03/08/24 at 11:57 AM, the ADON said she did not see the orders on 02/16/23 until on 03/06/24 when it was brought to her attention by the Dietitian, and she looked back to her emails, and she noticed there was an order for weekly weights for 4 weeks. She stated the supplement orders were updated but she missed the weights. She stated failure to follow the dietitian orders put Resident #18 at risk for continuing to lose weights. She revealed the weights were not monitored for the 4 weeks and she notified the doctor. Interview on 03/08/24 at 12:20 PM with Dietitian revealed she had noted on 2/16/24 that Resident #18 was losing weight and she recommended med pass 120mls three times a day and frozen nutrients and weekly weights but the weekly weights were not done by the time she reviewed the resident on 03/06/24. She stated the resident was receiving the supplements and the BMI was good. Observation on 03/08/24 at 1:38 PM of the reweighing of Resident #18 revealed she weighed 142.4 pounds. A review of the facility's policy on Resident Weight dated 02/13/07 indicated the following: .All residents must be weighed as indicated, unless otherwise ordered by the attending physician. .8. The facility review weights after monthly weights are obtained, to determine residents with significant weight changes. 9. All significant weight changes will be referred to the regional dietitian on the next visit. Regional dietitian will review all facility interventions, and will make appropriate recommendations, which will be approved by the physician if necessary.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one of three residents (Resident #47) reviewed for contracture management. The facility failed to apply rolled wash cloths to Resident #47's hands for contracture (a permanent tightening of the muscles) management. This failure could place residents at risk for a decline in range of motion, decreased mobility, worsening of contractures and a decline in physical capabilities. Findings included: Review of Resident #47's MDS dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included seizure disorder, respiratory failure, anoxic brain damage (complete lack of oxygen to the brain, which results in the death of brain cells), and persistent vegetative state. The MDS further reflected the resident had range of motion impairment to both sides of her upper and lower extremities. Review of Resident #47's care plan revised on 08/24/23 revealed Resident #47 had an ADL self-care performance as evidence by persistent vegetive state post anoxic brain injury, and the resident was totally dependent on staff for all ADLs. Approaches included to anticipate and meet the resident's needs. Observation on 03/06/24 at 11:28 PM of Resident #47 revealed she was in bed with her eyes open. Both of the resident's hands appeared to be contracted and there was no device in place. Resident #47 was not able to speak as she was in a vegetative state. Observation and interview on 03/07/24 at 2:53 PM revealed Resident #47 remained in bed with her eyes open and there was not a device in place in the resident's contracted hands. CNA E was in the room about to provide the resident care and stated Resident #47 normally had rolled up wash cloths in her hands daily. The CNA stated the rolled wash cloths were usually put in the resident's hands by therapy or the nurses. CNA E slowly opened both of Resident #47's hands to check the skin integrity and the palms were clean, free of odor, and intact and her fingernails were cut short. Interview on 03/08/24 at 11:48 AM with LVN F revealed Resident #47 usually had rolled wash cloths in her hands for her contractures and the nurses were responsible for making sure they were in her hands and the aides would also put them in there if they needed to. LVN F said she had not noticed the hand rolls had not been placed and no one had mentioned it to her. LVN F further stated it was important to keep the wash cloths in the resident's hands to keep the contractures from worsening. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/07/24 at 3:18 PM with the Director of Rehabilitation revealed she had just taken over the role of therapy director the week prior. She stated Resident #47's hands warranted a hand roll to keep the resident's fingernails from pushing into her skin due to her hand contractures. The Director of Rehab further stated she would be picking the resident up for therapy services and would make sure there would be something in place for the resident's contractures. Interview on 03/08/24 at 2:44 PM with the ADON revealed if residents had contractures to both hands then the residents should have a carrot or a rolled up towel in place to prevent the contracture from worsening and to avoid skin breakdown. The ADON further stated Resident #47 should have had an order to a hand roll to remind the nurses the residents should have them in place.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of six residents (Resident #53) reviewed for accidents. The van driver failed to properly restrain Resident #53's wheelchair in the facility transportation van to prevent the wheelchair from tipping over on its side on the way to dialysis on 03/05/24. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Review of Resident #53's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included heart failure, end stage renal disease , diabetes, stroke, and dependence on renal dialysis. Resident #53 had a BIMS of 15 which indicate her cognition was intact, and had the ability to understand and be understood. The MDS further reflected the resident required the use of a manual wheelchair. Review of Resident #53's care plan initiated on 10/08/23 reflected she required dialysis related to end stage renal failure. Observation and interview on 03/06/24 at 1:34 PM with Resident #53 revealed she was lying in bed in her room. The resident stated the day prior, 03/05/24, the Van Driver helped push and load her in the facility transportation van and he strapped her in as he always did. Resident #53 said they left the facility and were stopped at the traffic light and once the light turned green, the Van Driver must have taken a rapid sharp turn because it caused her wheelchair to lean to the right side and her right arm was resting on the van window/wall. She said the Van Driver noticed the wheelchair leaning on its side on two wheels and he stopped and re-adjusted her. Resident #53 said her right arm was hurting although there was no bruising noted at the time and the incident had scared her. The Van Driver kept apologizing to her and asking her if she was in pain to which she told him she was in pain. After she was repositioned, they continued the trip to the dialysis center. The resident further stated that was the first incident where her wheelchair had tipped on its side . Observation at this time, revealed there was no bruising or swelling noted to Resident #53's arm at the time of the observation. The resident stated she was sent to the hospital after she returned to the facility per her family's request and she said the hospital diagnosed her with a contusion. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/24 at 1:19 PM with the Van Driver revealed he had strapped Resident #53 in the facility van properly as he always did and stated he double checked to make sure the wheelchair did not move. Once he got to a traffic light, he made a left turn and he heard a noise and noticed Resident #53 was leaning to the right side against the window, tilted on the two right wheels and the left two wheels were off of the floor. The Van Driver said he stopped the van and put all the wheels on the van floor and checked to make sure all the wheelchair locks were still in place. The Van Driver asked the resident three times if she was ok to which she said she was and denied having any pain and asked the resident what she wanted to do, and the resident said she wanted to go to dialysis. Once they got to the dialysis center the Van Driver asked the resident again if she was ok and the resident said yes. The Van Driver further stated he should have contacted the facility or Administrator when the incident occurred and did not know why he did not. Interview on 03/08/24 at 2:10 PM with LVN C revealed the day of the incident, 03/05/24, after 3PM the resident was brought back from dialysis and the resident was complaining of pain to her right arm. LVN C said she was told about the incident that had occurred that morning in the van and the resident mentioned hitting her shoulder on the van wall . LVN C said she assessed Resident #53's right arm and there was no bruise, redness, or swelling noted. The LVN also said she touched and palpated where the resident was complaining of pain to her arm and did not feel any bumps but Resident #53 was medicated because she stated she was in pain. The resident's family called the facility, very upset about the situation and requested the resident be sent out to the hospital for x-rays and evaluation. Resident #53 returned to the facility shortly after being sent out and there were no new orders and the x-rays were negative for any fractures. Review of Resident #53's hospital records dated 03/05/24 reflected the following: .Final Course of action/assessment [AGE] year-old female presenting for right shoulder pain secondary to blunt trauma. Imaging negative for acute pathology (severe and sudden onset). Patient well-controlled with medication given in ED. No further imaging/lab workup necessary for this patient. Interview on 03/08/24 at 2:40 PM with the DON revealed LVN C told her about the van incident after Resident #53 returned from dialysis on 03/05/24. The DON said she went to the resident's room to get the full story from the resident and the resident told her she was having pain to her right arm. During the nursing assessment, there was no bruising or swelling noted and she did not feel bumps or swelling when she touched the resident's arm. The DON said she assessed Resident #53 again the day prior, 03/07/24, and again there was not bruising noted to the resident's right arm . Interview on 03/08/24 at 2:52 PM with the Administrator revealed the DON made her aware of the van incident with Resident #53, on 03/05/24. The Administrator went to the resident's room and the resident recounted her story about the incident and the resident stated her right arm was sore. They offered Resident #53 in-house x-rays but the resident's family wanted the resident sent to the hospital for an evaluation. The Administrator said she would have expected the Van Driver to notify her of the incident with Resident #53 or any other incident out of the ordinary during a van transport. Review of the facility's policy titled Transportation of a Resident (non-emergency) dated 2003 reflected the following: (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's requiring transportation in non-emergency situations to and from the nearest medical service provider by a facility employee in a safe manner. .7. The driver must report any event of injury during transportation immediately to the supervisor of the facility.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42859 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and expired medications were removed for one of four medication carts (200 Hall medication cart) reviewed for labeling and storage. 1. The facility failed to ensure Vitamin B12 vials that were expired were removed from the 200 Hall medication cart. 2. The facility failed to ensure insulin was dated with the open dates on the 200 Hall medication cart. These failures placed residents at risk of receiving medications that were ineffective due to having expired vitamin B12 vial on the cart and not putting an opening date on insulin pens. Findings included: Observation on 03/07/24 at 1:30 PM of the nurse's medication cart used for the Hall 200 with LVN A revealed one insulin vial of Humalog Subcutaneous Solution 100 unit/ml vial that was opened, partially used, with no open date and a vial of Vitamin B12 with an expiry date of 9/2023. Interview on 03/07/24 at 1:45 PM with LVN A revealed it was all nurses' responsibility to check the carts for expired medication and for the open dates on insulins. She stated she had checked the cart, and she did not notice the insulin did not have an open date. Also, she did not see the expired vials for Vitamin B12. She stated the effects of having expired medications on the cart was that if administered they might not be effective. LVN A stated if the insulin was not dated the staff could not tell when it expired. She stated the insulin were good for 28 days. If used, the blood sugar would not be controlled. She stated she had completed training on labeling and storage of insulin. Interview on 03/08/24 at 11:15 AM with the DON revealed her expectation was for nurses to check for the open dates and expired medications in their carts. She stated if insulin was not labeled with an open date, it would be hard to tell when insulin expired. If administered, it could be less effective and residents' blood sugars would not be controlled. The DON stated Humalog insulin vials were good for 28 days after opening. The DON stated if expired medications were not being removed from the carts and if administered, they would not be effective. She stated she did not remember whether she had done training with staff, and no in-service record was presented. Record review of the facility's current Types and Actions of Insulin policy, dated 2003, did not address opening dates. A policy addressing expired medications was requested on 03/08/24 at 12:00 PM and was not provided.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 24 residents (Resident #38) reviewed for resident call system. The facility failed to ensure Resident #38 had a working call light. This failure could have placed residents at risk of being unable to obtain assistance when needed. Findings included: Review of Resident #38's MDS revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included chronic kidney disease, chronic atrial fibrillation (irregular/rapid heart rhythm), and muscle weakness. The MDS further reflected Resident #38 had impairment to one side of her upper and lower extremities and used a wheelchair for mobility. Review of Resident #38's care plan revised on 02/21/24 revealed she had an ADL self-care deficit related to impaired mobility/hemiplegia (paralysis that affects only one side of your body), cognitive deficits, and contracture (a permanent tightening of the muscles). Interventions included she was totally dependent on staff for incontinent care and required the assistance of one staff to reposition and in bed. Observation and interview on 03/06/24 at 10:30 AM while on the 200 hall revealed Resident #38 was heard yelling for someone to help her. The resident was in bed and stated she needed staff to change her brief. Resident #38 also said she had pushed her call light, and someone had entered earlier but never returned. The resident's call light remained in reach, and she was asked to push it again and the light outside of the room was noted to not turn on. Further observation on 03/06/24 at 10:59 AM revealed the ADON entered the room to check on Resident #38. It was noted the call light was not plugged in correctly in the wall. Once the call light was plugged in, the resident's call button began to work, but the inside reset button would not turn the call light off when it was pushed. At that time, the ADON stated they would let the Maintenance Director know to check on the call light. Interview on 03/08/24 at 11:51 AM with LVN F revealed she was not aware Resident #38's call light was not working on 03/06/24. The LVN stated the resident was alert and oriented and able to use her call light when the resident needed to be changed. Interview on 03/08/24 at 12:41 PM with the Maintenance Director revealed he checked all resident call lights once a month and Resident #38's call light was working the last time he checked. He stated he was made aware on 03/06/24 by the ADON that Resident #38's call light was not working and when checked it appeared the reset button inside the room had gotten stuck and he also replaced the call light cord and it was back working normally. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Maintenance Director's call light log revealed he checked the call light on hall 200 on 03/04/24, which included Resident #38's room, and it was documented that all the call lights were functioning. Review of the facility's Resident Rights dated 2011 reflected the following: .ensure that each resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the health care center.		