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	06/25/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who need respiratory care were provided such care, consistent with professional standards of practice for 1 of 3 residents (Resident #9) reviewed for oxygen orders. The facility failed to ensure Resident #9 was receiving oxygen at 2-4 liters per minute as ordered by the physician.This failure could place residents at risk of receiving incorrect or inadequate oxygen support, resulting in a decline in health.Findings included: Record review of Resident #9's Quarterly MDS assessment dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, unspecified whether with hypoxia (low levels of oxygen in the body tissues) or hypercapnia (elevated carbon dioxide in the blood), tracheostomy status (an incision in the windpipe made to relieve an obstruction to breathing), respiratory failure, and hypertension (high blood pressure). The MDS reflected that the resident's cognition was intact with a BIMS score of 14, and he received oxygen therapy and tracheostomy care.Record review of Resident #9's care plan, dated 05/27/26, revealed Focus: [Resident #9] has Oxygen Therapy. Goal: The resident will have no s/sx of poor oxygen absorption through the review date. Interventions: Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD. Focus: The resident has Pneumonia. Goal: The resident's pneumonia will be resolved without complications by review date. Interventions: Oxygen therapy as ordered. Record review of Resident #9's physician order dated 05/08/26 revealed May use oxygen @_2-4 l/m via trach every shift related to Acute and Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia.Observation on 06/23/26 at 11:10 a.m. revealed Resident #9 was in his room, lying in bed sleeping. Resident #9 was receiving 4.5 liters of oxygen via nasal cannula (device that provides oxygen therapy through the nose). Observation and interview on 06/24/26 at 9:35 a.m. with Resident #9 revealed he had his oxygen nasal cannula in place, and the oxygen concentrator (a medical device that provides supplemental oxygen) was set at 5 liters per minute. Resident #9 stated he should be on 3 liters. He stated it felt like he was on 3 liters and not 5 liters. Resident #9 stated he did not have shortness of breath or difficulty breathing. Observation on 06/24/26 at 4:05 p.m. revealed Resident #9 was sleeping with his nasal cannula in place. Resident #9's oxygen concentrator was set at 5 liters per minutes. Observation and interview on 06/25/26 at 10:08 a.m. with Resident #9 revealed he had his oxygen nasal cannula on at 5 liters. Resident #9 denied having any shortness of breath. Resident #9 stated he had not seen anyone adjust his oxygen concentrator. During an observation and interview on 06/25/26 at 10:12 a.m., LVN C stated she was the nurse assigned to Resident #9. She stated Resident #9 was supposed to be on 3 liters of oxygen continuously. LVN C entered Resident #9's room and checked on Resident #9's oxygen flow rate. LVN C stated the resident was not supposed to be on 5 liters. She stated she was not aware Resident #9's oxygen flow rate was at 5 liters. LVN C stated she did not check Resident #9's oxygen flow rate when completing her rounds. She stated that she only checked the humidifier bottle to ensure there was water. She stated she could not recall when the last time she checked on Resident #9's oxygen flow rate. LVN C stated she was also the nurse assigned yesterday (06/24/26), and she did not check the (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen flow rate. She stated the potential risk of not following physician orders would be harmful to the resident, could cause hypoxia. Interview on 06/25/26 at 10:55 a.m., the ADON stated for residents receiving oxygen all the nurses were expected to check the residents' oxygen levels every shift to ensure they were at the correct oxygen setting, and following physician orders. She stated it was the responsibility of the nurses to ensure oxygen settings were correct. The ADON stated she and the DON were responsible for completing spot checks to ensure the nurses were following physician orders. She stated the potential risk of not following physician orders was that it could exacerbate the residents' symptoms if they were administered too much oxygen. Interview on 06/25/26 at 11:21 a.m., the DON stated for residents receiving oxygen the nurses were expected to check residents' oxygen levels and deliver oxygen per physician orders. She stated the nurses were responsible for ensuring they were following physician orders and ensuring oxygen settings were correct. The DON stated she and the ADONs were responsible for following up and ensuring nurses were following physician orders. She stated if oxygen was not administered correctly, the potential risk for residents would be shortness of breath and anxiety. She stated if residents were administered more than what the orders indicated, it could lead to hyperoxygenation (excessive oxygen in the lungs or other body tissues) and could affect oxygen levels. Record review of the facility's, Oxygen Administration revised 03/21/23, revealed the following: The amount of oxygen by percent of concentration or L/min , and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. 1.The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #39) reviewed for medication errors.The facility failed to hold Resident #39's Carvedilol and Hydralazine per the recommended and prescribed heart rate parameters on 06/01/26, 06/04/26, 06/08/26, 06/12/26, 06/13/26, 06/14/26, 06/15/26, 06/16/26, 06/17/26, 06/20/26, 06/21/26, 06/22/26, and 06/24/26.This failure could place residents who receive blood pressure and pulse altering medications at an increased risk for complications such as decreased blood pressure, decreased pulse, and potential hospitalization.Findings included: Record review of Resident #39's Annual MDS, dated [DATE], reflected he was a [AGE] year-old male, who admitted on [DATE] with diagnoses that included: hypertension (high blood pressure). The MDS reflected Resident #39's cognition was intact with a BIMS score of 15. Record review of Resident #39's care plan, dated 05/04/26, revealed the resident had hypertension and was receiving medications to manage it with interventions to give anti-hypertensive medications as ordered and monitor for side effects. Record review of Resident #39's June 2026 active physician orders, revealed as follows:*Coreg (Carvedilol) 25 mg (medication used to treat high blood pressure), give 1 tablet by mouth 2 times a day for hypertension, hold for SBP [the pressure in the arteries when the heart beats] < 100 and DBP [the pressure of blood pushing against the artery walls while the heart rests] <60 or HR [the speed at which the heart beats] <60, with a start date of 03/11/25. *Hyralazine 100 mg (medication used to treat high blood pressure), give 1 tablet by mouth 3 times a day, hold for SBP < 100 and DBP <60 or HR <60, with a start state of 01/31/25. Record review of Resident #39's June 2026 MAR revealed 7:00 AM HR vitals: *06/01/26 his HR was 59, *06/04/25 his HR was 59, *06/08/26 his HR was 57, *06/12/26 his HR was 55, *06/13/26 his HR was 59, *06/14/26 his HR was 58, *06/15/26 his HR was 56, *06/16/26 his HR was 59, *06/17/26 his HR was 59, *06/20/26 his HR was 59, *06/21/26 his HR was 58, and *06/22/26 his HR was 55. The MAR revealed that both the Carvedilol and Hydralazine were administered on each of these dates by MA B. During an observation on 06/24/26 at 7:06 AM, MA B obtained Resident #39's vital signs. Resident #39's blood pressure was 139/81 and his HR was 59 beats per minute. MA B was observed administering Resident #39's Carvedilol and Hydralazine, in addition to his other scheduled medications. Resident #39's HR was less than 60. During an interview on 06/24/26 at 7:42 AM with MA B, he stated he did administer the Carvedilol and Hydralazine to Resident #39. He stated the orders stated to hold if the HR was less than 60. He stated Resident #39's HR was 59, so he should not have administered the medications without checking with the nurse first. He stated the check marks on the MAR meant the medications were administered. MA B stated he normally communicated with the nurse and would recheck the vitals for a second or third time, but that he had not notified the nurse. MA B stated he knew not to administer if the BP was lower but had missed the HR. MA B stated the risk of administering blood pressure medications without following the parameters were the blood pressure or HR could become lower. During an interview on 06/24/26 at 9:55 AM with LVN C, she stated most blood pressure medications had parameters and that she expected her medication aides to notify her if the BP or HR were below parameters so she could double check it. LVN C stated she would notify the physician if the vital signs were below the parameters. LVN C stated she had not been notified of Resident #39's vital signs. She stated the risk of not following the parameters was the resident's HR or BP could drop. LVN C stated it was her and the other nurse's responsibility to ensure the medication aides were following the orders. During an interview on 10:11 AM with the DON, she stated she expected her staff to not give medications if it was not within the ordered parameters. She stated the MA was supposed to notify the nurse and the nurse could contact the physician. The DON stated the parameters were in place to protect the resident. She stated the risk of giving medications without following the parameters was the resident could have a reaction to that and it could lower the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BP or HR. The DON stated she was ultimately responsible for ensuring the orders were following, but all the nurses as well. The DON stated the MA was responsible for notifying the nurse if the medication was outside of the ordered parameters. During an interview on 06/25/26 at 10:14 AM with the facility's Medical Director, she stated that she expected staff to follow the parameters set on the medications. She stated the nurses were good about notifying her if something was wrong, but that she had not been notified previously regarding Resident #39's HR. The Medical Director stated the risk of not following her order parameters was the HR and BP could decrease more and potentially cause an adverse reaction. During an interview on 06/25/26 at 10:46 AM with the ADON, she stated she expected staff to follow the parameters on any blood pressure medications. She stated there was usually a BP and a pulse parameter on each medication and that staff were supposed to hold it if it was below the parameters. The ADON stated the MA should notify the nurse and the nurse could notify the physician. She stated the nurses were responsible for ensuring the parameters were followed by the MA. The ADON stated the risk of the parameters not being followed was the pulse or blood pressure could drop even lower. Record review of the facility's, Medication Administration Procedures, revise 10/25/17, revealed the following: .20. The 10 rights of medication should always be adhered to 1.Right patient 2.Right medication 3.Right dose 4.Right route 5.Right time6.Right patient education 7.Right Documentation 8.Right to refuse9.Right assessment10.Right Evaluation