STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676416	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightpointe at Lytle Lake	1201 Clarks Dr Abilene, TX 79602

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on interview and record review the facility failed to ensure residents/resident's representative had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 1 of 1 resident (Resident #1) reviewed for resident rights. Resident #1 had no consents for the antianxiety medication, Clonazepam, Ativan, Divalproex and Temazepam. Resident #1 had no consents for the antipsychotic medication Risperidone, Aripiprazole, and Haloperidol. These failures could place the resident, who received care at the facility, at risk of not being informed of their health status, to make informed decisions regarding their care. The findings included: Record review of Resident #1's Electronic Admission Record dated 04/05/2024 revealed she was a [AGE] year-old female originally admitted to the facility 01/11/2024 with a most recent admitted [DATE]. She had diagnoses which included Cerebral Palsy, Bipolar disorder with psychotic features, Depression, Anxiety, and Autistic Disorder. Record review of Resident #1's MDS assessment dated [DATE] revealed: Section C- Cognitive Patterns a BIMS score of 0 out of 15 (severe impairment), short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention and disorganized thinking. Section D-Mood revealed; Trouble falling or staying asleep, or sleeping too much nearly every day, being short-tempered and easily annoyed 7-11 days out of a two-week period. Social Isolation being the resident is unable to respond. Section E-Behaviors revealed; Physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others, with rejection of care and wandering present. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section GG-Functional Abilities and Goals revealed; substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for eating, oral hygiene, and toileting hygiene, upper/lower body dressing, taking on/off footwear and personal hygiene. Shower and bathing herself had not been attempted. Resident also needed Substantial/maximal assistance for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfers, toilet transfer, walk 10 feet, walk 50 feet, and walk 150 feet. Section N-Medications-High-Risk Drug Classes: Use and Indication revealed: Medications received were antipsychotic 7/7 days, antianxiety 7/7 days, and antidepressant 7/7 days. Section N-Medications-Antipsychotic Medication Review revealed; Antipsychotics were received on a routine basis only. Section Q - Participation in Assessment and Goal Setting (Identifying all active participants in the assessment process) revealed; Family and Legal guardian. Record review of Resident #1's Electronic Order Summary on 04/04/2024 at 3:07pm revealed the following physician orders; ARIPiprazole 5mg at bedtime for behaviors related to bipolar disorder, current episode mixed, severe, with psychotic features (initial start date 01/11/2024; discontinue date 04/02/2024) Ativan 1mg every 4 hours as needed for agitation (initial start 01/20/2024; discontinue date 04/02/2024) ClonazePAM 1mg three times a day for anxiety (initial start date 01/11/2024, discontinue date 03/19/2024) ClonazePAM 1mg four times a day related to anxiety disorder, autistic disorder (initial start date 03/19/2024, discontinue date 04/02/2024) Divalproex Sodium Delayed Release Spring 250mg two times a day related to seizures (initial start date 01/24/2024, discontinue date 04/02/2024) Haloperidol Lactate Oral Concentrate 2.5mg every 4 hours as needed for agitation/aggressiveness for 2 days (initial start date 01/14/2024, discontinue date 01/15/2024) Haloperidol Lactate Oral Concentrate 6mg STAT for extreme agitation related to cerebral palsy (initial start date 01/13/2024, discontinue date 01/13/2024) medroxyPROGESTERone Acetate Intramuscular Suspension 150mg one time a day every 3 month(s) starting on the 28th for 1 day(s) for behaviors (initial start date 01/28/2024, discontinue date 04/02/2024) Perseris Subcutaneous Prefilled Syringe 120mg one time a day every 1 month(s) starting on the 26th for 1 day(s) related to bipolar disorder with psychotic features (initial start date 01/26/2024, discontinue date 04/02/2024) (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Risperidone 2mg two times a day related to anxiety disorder and autistic disorder (initial start date 01/11/2024, discontinue date 04/02/2024) ZyPREXA Intamuscular Solution 10mg every 24 hours as needed for agitation (initial start date 03/16/2024, discontinue date 04/02/2024) ZyPREXA 5mg one time a day related to bipolar disorder with psychotic features (initial start date 03/16/2024, discontinue date 04/02/2024) Record review of Resident #1's Electronic Medical Record revealed no evidence of signed consents for ARIPiprazole, Ativan, ClonazePAM, Diavalproez, Haoperidol, medroxyprogesterone, Perseris, Risteridone, and ZyPREXA. During an interview on 04/08/2024 at 11:16 AM, the DON stated Resident #1 was not a patient of the Psychiatric doctor but of the facility Medical Director. She stated she could not guarantee there were consents filled out because Resident #1's Representative lived in a different town. She stated the consent would have been a verbal consent. She stated regional management told her had to be wet signature (signature on a physical paper document with penned signatures rather than electronic or digital signatures) for psych meds. During an interview on 04/08/2024 at 11:27 AM, MR stated she did not have any signed consents available to be uploaded for Resident #1. She stated the ADON and DON monitored those. Once they had the consents completed, they would have provided them to her to be uploaded into the resident's electronic chart. During an interview on 04/08/2024 at 11:30 AM, the ADON stated she had been out sick and had gotten behind on consents. She then provided an undated and unsigned 3713 consent form with all of Resident #1's antipsychotics and antianxiety medications (Aripiprazole, 5 mg, Clonazepam 1mg, Risperidone2 mg/ml, Ativan 1 mg, Divalproex Sodium, Temazepam 15 mg). The ADON stated the 3713 had been filled out on 03/15/2024 but was not signed by the Resident Representative or MD. She stated this form provided was the only consent form she had for Resident #1. The ADON stated the MD came to the facility weekly and signs the forms. She stated she does not know why this form has not been signed since the MD had been at the facility weekly. She stated there were no other consents for antipsychotics and antianxiety medications. During a follow-up interview on 04/08/2024 at 11:35 AM, the DON stated she did not know why Resident #1's consent form 3713 was not signed and did not want to make a guess. She stated since the MD had been to the facility several times since the 3713 forms had been printed, the MD should have signed the form as well as having had the Representatives signature. During a follow-up interview on 04/08/2024 at 11:37 AM, MR stated the nurses filled out the consent forms and then would go to her for filing and uploading. She stated she had not seen this consent form (3713), but usually would not get them until they were completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brightpointe at Lytle Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Clarks Dr Abilene, TX 79602	

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/2024 at 2:20 PM, the MD stated he visited this facility on a weekly basis and made sure all signed consents for each resident were completed while there. He stated for Resident #1 he had not signed her consents as she was in the hospital and was not physically there at the facility. The MD stated he did have consents at his office and not at the facility, but only had his signature on them and not the representatives. He stated for the medications being prescribed, the consents were supposed to have all signatures in place which also included the RR's signature. During an interview on 04/08/2024 at 4:12 PM, Resident #1's Representative stated she had not signed any consents concerning Resident #1's medications. She also stated she had not received any emails or phone calls concerning consents. She stated the only paperwork she had signed since Resident #1's admission was the admission packet. During a follow-up interview on 04/09/2024 at 3:48 PM the DON stated she had thought Resident #1's representative would come visit at the facility and had not sent or used any other means of communication to get the consents signed. The DON stated herself as well as the ADON monitored the consent forms and making sure they were signed either by the resident or RR. She stated once signed; the consent forms should go to MR for them to upload in the EMR. The DON stated the negative impact to residents could have been, the RR not knowing and/or understanding what their loved one's medications may have been as well as a negative side effect. She stated the failure occurred in not having the consents signed where needed, as well as not documenting and not having other means of communication with the RR to get that completed. She stated she had not tried alternate methods of completing the consent forms with the RR, and that would have been her expectation in doing that as well as being available in the resident chart. During a follow-up interview on 04/09/2024 at 5:45 PM, the DON stated to her Corporate Office that she had not reached out to Resident #1's representative by any other means such as email and/or phone, nor had any documentation of doing so. The facility provided the Texas HHSC Long-Term Care Regulatory Provider Letter Titled Consent for Antipsychotic and Neuroleptic Medications dated May 5, 2022 revealed: 2.0 Policy Details & Provider Responsibilities Under 26 TAC S554.1207, a resident receiving antipsychotic or neuroleptic medications must provide written consent. Written consent can also be given by a person authorized by law to consent on the resident's behalf. Consent for antipsychotic and neuroleptic medications must be documented on Texas Health and Human Services Commission (HHSC) Form 3713. 2.2 The prescriber of the medication, the prescriber's designee, or the NF's medical director must complete Section I of Form 3713 . .The resident or the resident's legally authorized representative must sign Section II of Form 3713. The rule requires consent in writing by the resident or by a person authorized by law to consent on behalf of the resident. Verbal consent does not meet the rule requirements. NF cannot sign on behalf of the resident. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The original Form 3713 or a copy of the completed form must be kept in the resident's clinical record to meet the consent requirement. Copies could be mailed, faxed, or securely emailed if all parties are unable to sign the form in one sitting. Any copy or original consent form must be accurately completed and contain all required information applicable signatures. 2.3 The person prescribing the medication, the prescriber's designee, or the NF's medical director must provide the resident, and if applicable, the person authorized to consent on behalf of the resident, the following information: The condition being treated; The beneficial effects on that condition expected from the medication; The potential side effects of the medication; The associated risks of the medication; and The proposed course of medication Record Review of Facility Action Plan dated 12/26/2023 revealed: Problem: Psychotropic Consent Form 3713 has not been completed for all resident receiving atypical antipsychotic medication. Appropriate DX is not present for all residents receiving antipsychotic medication. Goal: 1. All residents that receive antipsychotic medications will have completed form 3713 in their EMR. Goal date: 01/31/2024 2. All residents that receive antipsychotic medications will have appropriate CMS approved DX to justify antipsychotic medications. Goal date: 01/31/2024 Approaches: 1. DON or designee will review order summary daily. If new order for antipsychotic is received, DON or designee will ensure proper 3713 form is completed and CMS approved DX is present for medication. Responsible person(s) DON or designee 2. If appropriate DX is not present, DON or designee will contact provider to request appropriate DX or ask for new order for medication that is appropriate for resident's DX, making sure schizophrenia and schizoaffective DX's have supporting documentation following CMS guidelines. Responsible person(s) DON or designee (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. DON or designee will perform an audit of all residents in facility, with antipsychotic medications, to ensure that each resident with antipsychotic orders, has a form 3713 in place, and DX is appropriate for medication order. Responsible person(s) DON or designee 4. DON or designee will speak with pharmacy consultant to request an audit upon each visit, to ensure proper DX is in place and form 3713 is in place for any residents on antipsychotic medication. Responsible person(s) DON or designee 5. DON or designee will notify providers for residents with antipsychotic medication orders, that do not have CMS approved diagnosis, to request appropriate DX, or new order more appropriate for current diagnosis. Responsible person(s) DON or designee 6. DON or designee will ensure DDR attempts continue at least quarter for residents who receive antipsychotic medications. Responsible person(s) DON or designee 7. Form 3713 will be scanned into EMR for all residents who receive antipsychotic medications with wet RP signature and physician signature. Responsible person(s) DON or designee 8. Pharmacy consultant to review all current antipsychotics and make recommendations to adjust antipsychotic medication for resident without appropriate DX for medications. Responsible person(s) **Monitoring: DON and discussed monthly in QAPI

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44728 Based on interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property for 1 of 8 (CNA-A) employees reviewed for employability. Facility staff did not have criminal history check and/or an EMR/NAR check prior to offering employment to the facility and/or annually for employees. These findings placed residents at risk of receiving care by someone that was unemployable. The findings included: Review of facility document titled Criminal History, Employee Misconduct (EMR), Nurse Aide Registry (NAR) Employee Acknowledgement not dated revealed: Before a person can be hired by [facility], the facility will conduct a criminal history check within 24 hours and prior to working the floor. A copy of the findings will be printed and maintained by the facility. In addition, the facility will search the Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR), which is maintained by Department of Aging and Disability Services (DADS), to determine whether the person is designated in either registry as having abused, neglected, or exploited a resident or a consumer of a facility, or misappropriated a residents' or consumers' property. Verification that the EMR and NAR have been searched prior to employment will be documented, and a copy of the findings will be printed and maintained by the facility. Record review of the CNA-A's personnel file revealed a hire date of 08/02/2022. There was no documented evidence of a Criminal History check prior to employment. There also was no initial or annual EMR/NAR check found in the file. During an interview on 04/09/2024 at 1:45 PM, HR stated CNA-A did not have any documents in her personnel file other than her application when hired on 08/02/2022. The HR stated that it makes her mad since this staff member had been at the facility for almost two years. HR stated she had only been hired since 02/22/2024 with MA being the previous HR hired. She stated all staff should have had a criminal history check before being hired as well as an initial and yearly EMR/NAR, but it depended on the staff member's credentials. HR stated CNA-A had neither of these forms in her personnel file. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/09/2024 at 3:06 PM, MA stated she previously had been hired as the facility HR in 08/2023. She stated she then had been offered the MA position and worked both areas up until the current HR was hired in 02/2024. She stated the duties she was responsible for as HR were to make sure new employee's orientation paperwork was completed and that included Criminal History Background checks before hire as well as EMR/NAR checks. She stated she had noticed when she was HR, criminal history background and EMR/NAR verifications had not been done by the previous agent. MA stated and highly agreed that CNA-A should have had more than only her application in her personnel file from two years ago. She stated while in HR she had gone through each one (personnel file) to see what was missing or not. MA stated that failing to conduct proper criminal history background and EMR/NAR verifications prior to employment and annually to impact the residents potentially negatively by not ensuring the residents were free from staff who had an abusive or neglectful background. During an interview on 04/09/2024 at 3:17 PM the ADMN stated the staff were required to have a criminal background check as well as documented EMR/NAR check had been done. He stated the facility had not had a consistent HR. He stated CNA-A should have more in her personnel file than her application since she was hired in 2022. He stated that nursing services, the DON and ADON, should have monitored and followed up to make sure criminal background and EMR/NAR verifications were completed. The ADMN stated residents could be negatively impacted if the facility allowed employment of staff members who had a previous conviction. He stated it would depend on what it was for in what the negative impact could have been. He stated his expectations were that criminal background history and EMR/NAR verifications should have been completed. Need to include ADMN interview on what the policy states about doing criminal history background & EMR/NAR Verifications. During an interview on 04/09/2024 at 3:48 PM the DON stated she did not have a process for making sure her nursing staff had Criminal Background checks, and EMR/NAR checks. She stated she relies on HR for that type of paperwork. The DON stated all staff background checks should be completed prior to being hired. She stated the negative impact to residents for staff not having a background check done could possibly have led to abuse and/neglect. The DON stated she was not sure who was responsible to ensure criminal background and EMR/NAR verifications were to be completed She stated she could not make up an answer for what the failure was, but stated she felt it was HR as well as previous HR. The DON stated her expectations were for all background checks and all nursing services documentation be completed and provided into each staff members' personnel file. Record review of New Hire checklist revealed there was no evidence of a Criminal History Employee Acknowledgement or EMR/NAR Acknowledgement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment were reported immediately but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #1) of 1 resident reviewed for abuse or neglect. The facility failed to report to the State Survey Agency allegations of Abuse and Neglect when learning of a positive hospital lab result for Cannabis for Resident #1. This failure could affect residents by placing them at risk of not having incidents of abuse and neglect being reviewed and investigated in a timely manner by the facility and State Survey Agency. The findings included: Record review of Resident #1's Electronic Admission Record dated 04/05/2024 revealed she was a [AGE] year-old female originally admitted to the facility 01/11/2024 with a most recent admitted [DATE]. She had diagnoses which included Cerebral Palsy, Bipolar disorder with psychotic features, Depression, Anxiety, and Autistic Disorder. Record review of Resident #1's MDS assessment dated [DATE] revealed: Section C- Cognitive Patterns a BIMS score of 0 out of 15 (severe impairment), short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention and disorganized thinking. Review of Resident #1's hospital urine laboratory drug screen results dated 03/31/2024 at 1:22pm revealed: Cannabinoids (also known as marijuana). = POSITIVE. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/2024 at 3:54 PM, the ADMN stated he was the facility's abuse coordinator. ADMN stated he first had knowledge of Resident #1's positive drug screen on 04/04/2024 around 3:30 PM. He stated his corporate company had notified him with the information. The ADMN stated he did not report it to HHSC due to checking other sources for possible drug interactions as well as waiting on Resident #1's hospital records. He stated it was hearsay and did not believe it should have been reported until he received the records. He stated that MA saw the lab was positive while visiting MR at the hospital but still had not been given proof of such readings. The ADMN then stated he had asked the corporate office if it should have been reported and was awaiting the answer of whether to report or not. He stated he did not know what the allegations would have fallen under, and then stated since this surveyor was there in his office asking these questions, it was already reported in a roundabout way. The ADMN stated he did not have the facility policy of reporting but went by HHSC Long Term Care Regulatory Provider Letter Titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to the Health and Human Services Commission. During an interview on 04/09/2024 at 3:48 PM, the DON stated they would have group meetings on if self-reporting should have been done. She stated herself as well as ADMN have had a meeting with corporate and they decided since this surveyor was in the facility, they would wait on Resident #1's hospital records. She stated the possible negative impact to residents would have been, if this lab were a true positive, other residents could have possibly been at risk or a positive drug screen. The DON stated she did not feel there was a failure in not reporting this to HHSC. She stated her expectations for reporting was for the ADMN to know when to report when needed. She stated he goes off of the HHSC Provider Letter of when you should report. Record Review of facility Admission Agreement, undated, revealed: Resident Abuse/Neglect Reporting: It is the policy of this facility that all personnel promptly report any incidents or any suspected incidents of resident abuse/neglect, including injuries of an unknown source. Upon a report of an allegation of resident abuse/neglect, the facility will investigate each instance to determine if the allegation did occur. The facility will report and notify the Texas Health and Human Services Commission as required by Texas law. Any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person must report the abuse, neglect, or exploitation, which includes conduct or conditions resulting in serous accidental injury to a resident or hospitalization of residents. Conduct or conditions means a facility practice, action/inactions by staff or circumstances within a facility resulting in: 1. Serious accidental injury to residents; or 2. hospitalization of residents As applied in this policy, the following words have the following meaning: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse-Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through word or physical action which causes or could cause mental or physical injury or death to a resident. This includes verbal, sexual, mental, psychological, physical abuse (including corporal punishment, involuntary seclusion, or any other mistreatment within this definition) Neglect .treatment or care to a resident which causes mental or physical injury or harm Per the States's Operation Manual, the facility will report the allegation to the Intake Coordinator, Investigations Section, Long Term Care-Regulatory Review of Long-Term Care Regulatory Provider Letter 19-17 titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) dated 07/10/2019 revealed: 2.0 Policy Details & Provider Responsibilities 2.1 Incidents that a NF Must Report to HHSC and the Time Frames for Reporting A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse Neglect Exploitation Death due to unusual circumstances A missing resident Misappropriation Drug theft Suspicious injuries of unknown source Fire Emergency situations that pose a threat to resident health and safety Review of Long-Term Care Regulatory Provider Letter 18-20 titled Incident Reporting Requirements dated 01/19/2023 revealed: 2.0 Policy Details & Provider Responsibilities A provider must: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Brightpointe at Lytle Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Clarks Dr Abilene, TX 79602	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o report reportable incidents to CII; o ensure a thorough investigation is conducted and documented in the PIR; and o submit the PIR to CII within the regulatory timeframe that applies to the provider type. In addition to reporting an incident, a provider must investigate, or ensure that an investigation was completed, to determine why it occurred, what actions the provider will take in response to the incident and what changes will be made to help prevent a similar incident from occurring. A provider must submit a PIR to CII using HHSC Form 3613-A (for use by an ALF, DAHS facility, ICF/IID, NF or PPECC) or HHSC Form 3613 (for use by a HCSSA). Please ensure you use the correct form for your provider type. The PIR must include all information from the initial incident report and any additional information the provider has obtained since making the initial report, including witness statements. The provider must submit the PIR within the applicable required time frame, as follows: o Five working days for an ICF/IID, NF or skilled NF; Review of TULIP website accessed 04/10/2024 revealed under the facility account no self-reported incident intake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightpointe at Lytle Lake	1201 Clarks Dr Abilene, TX 79602

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on record reviews and interviews, the facility failed to thoroughly investigate allegations of Abuse and Neglect for 1 of 1 resident (Resident #1) reviewed. The facility did not have documentation that a thorough investigation of allegations of Abuse or Neglect for Resident #1 who had a positive urine drug screen for Cannabinoids (also known as marijuana). This failure could place residents who report allegations of abuse/Neglect at risk of not being thoroughly investigated. The findings included: Record review of Resident #1's Electronic Admission Record dated 04/05/2024 revealed she was a [AGE] year-old female originally admitted to the facility 01/11/2024 with a most recent admitted [DATE]. She had diagnoses which included Cerebral Palsy, Bipolar disorder with psychotic features, Depression, Anxiety, and Autistic Disorder. Record review of Resident #1's MDS assessment dated [DATE] revealed. Section C- Cognitive Patterns a BIMS score of 0 out of 15 (severe impairment), short and long-term memory problems, severely impaired cognitive skills for daily decision making, inattention and disorganized thinking. Review of Resident #1's hospital urine laboratory drug screen results dated 03/31/2024 at 1:22pm revealed: Cannabinoids (also known as marijuana). = POSITIVE. Review of Facility's Incident Report files revealed no evidence of investigation of allegation of abuse and neglect for Resident #1. During an interview on 04/08/2024 at 3:54 PM, the ADMN stated he was the facility's abuse coordinator. ADMN stated he first had knowledge Resident #1 had a positive drug screen on 04/04/2024 around 3:30 PM. He stated his corporate company had notified him with the information. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brightpointe at Lytle Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Clarks Dr Abilene, TX 79602	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2024 at 3:17 PM, the ADMIN stated he did not feel there was a failure in not investigating. He stated he did not have all the evidence for a thorough investigation, and until he received all the evidence, he had no plans of investigating. The ADMN stated the negative impact for residents and not investigating could have possibly been, staff using drugs and harm other residents in their care. He stated he may should have investigated to be on the safe side, but then again, felt as though he could not take the hospital's word that the labs were correct in a positive result. The ADMN stated he had felt if HHSC was in the facility on the matter, that it was another reason for him not to do his own investigation as it was already getting investigated. He stated the policy revealed to him, he should investigate as well as confirm or unconfirm his findings. The ADMN stated his expectations for investigating were to have all the evidence and actively asking for the evidence until it was received. He stated he did not know what category/allegation a positive drug screen would have fallen under to do a thorough investigation. During an interview on 04/09/2024 at 3:48 PM the DON stated she helped investigations of self-reports if it involved the Nursing Services. She stated the risk management team and the ADMN monitored who should investigate. DON stated they were waiting on receiving for Resident #1's hospital records. She stated that failing to begin investigation with reported allegation of resident positive of illegal substance could place other residents at risk. Record Review of facility Admission Agreement, undated, revealed. Resident Abuse/Neglect Reporting: Upon a report of an allegation of resident abuse/neglect, the facility will investigate each instance to determine if the allegation did occur. The facility will report and notify the Texas Health and Human Services Commission as required by Texas law. Record Review of facility policy Conducting Internal Investigations undated, revealed: Policy: The purpose of this policy is to establish procedures for conducting internal compliance investigations. Procedure: 1. The Compliance Officer or designee shall begin and/or oversee investigations on all compliance-related matters following receipt of the report indicating a matter warranting investigation. 2. The Compliance Officer may delegate the investigation responsibilities but will hold ultimate supervision and responsibility for all compliance investigations. 3. The investigation may include, but is not limited to: a. Reviewing and preserving documents related to the matter; b. Interviewing appropriate individuals; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Reviewing policies and procedures applicable to the matter; d. Collaborating with a internal facility authority, as needed; e. Engaging an outside consultant, authority, law enforcement, or regulatory entity to assist in the investigation, as need. 4. If a significant compliance violation is found, the Compliance Officer and/or facility management shall develop and implement a corrective action plan. 5. If the investigation findings do not substantiate the allegation or matter: a. The investigation will be closed by the Compliance Officer. b. Documentation regarding the investigation will be filed and maintained by the Compliance Officer and the Facility Compliance Department after the investigation has closed. 6. If a compliance violation is found: a. All documentation related to the investigation will be maintained as an open investigation until a corrective action plan has been completed and the matter has been resolved, at which time the investigation will be closed by the Compliance Officer.