

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 11/06/2024
NAME OF PROVIDER OR SUPPLIER Brightpointe at Lytle Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883</p> <p>Based on interviews and record review the facility failed to allow residents to obtain a copy of their records or any portions thereof upon request and 2 working days advance notice to the RP for 1 of 5 (Resident #4) residents reviewed for the right to access copies of records.</p> <p>The facility failed to provide medical records for Resident #4 to her RP within two working days of a request on 10/29/2024.</p> <p>This failure could place residents and their representatives at risk by not having information about resident's care that was provided under the care of the nursing facility.</p> <p>Findings included:</p> <p>Record review of Resident #4's electronic face sheet dated 11/02/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: dementia. Further review of Resident #4's electronic face sheet revealed family member was Resident's responsible party.</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed: BIMS score of 02 which indicated severe cognitive impairment.</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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #4's admission agreement dated 4/28/2024 revealed Resident's family signature as legal representative. Further review of the admission agreement revealed: Upon an oral or written request to the facility, you have the right to access your records, including current clinical records. The nursing home must provide you access within 24 hours of your request (excluding weekends and holidays). After receiving your records for inspection, you have the right to purchase photocopies of your records at a cost that is not more than the standard rate in your community. The nursing home must provide you with the photocopies, upon request, within two working days advance notice to the facility . Right to Inspect and Copy. With limited exceptions, you have the right to inspect and copy protected health information that may be used to make decisions about your care. To inspect and copy protected health information maintained by the Center you must submit your request in writing to the Administrator or Medical Records Department. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to medical information, you will receive a written denial. You may request that the denial be reviewed. Thereafter, another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who originally denied your request. We will comply with the outcome of the review. We may charge you reasonable fees for copying your PHI.</p> <p>During an interview on 11/06/2024 at 1:50 p.m., the ADMN stated the procedure for releasing medical records was the resident or the POA would fill out a request for release of medical records form. He stated the form was then sent to corporate and the facility would wait for a response before releasing medical records.</p> <p>During a telephone interview on 11/06/2024 at 3:04 p.m., Resident #4's representative stated after she received Resident #4's death certificate, she went around to get health records. She stated she went to the facility and was told by the ADMN she didn't have to fill out any paperwork to receive medical records. She was unsure how long ago that was when she had originally asked the ADMN for medical records. She stated she did not hear back from the facility, so she spoke to the ADMN again who directed her to speak to MR. MR had her fill out a form to submit for medical record release. Resident #4's representative stated she was told it could take up to 2-3 weeks to get medical records. She denied getting a letter requesting payment for medical records or denial of medical record release. She stated she was upset that it had taken so long to get medical records and did not understand why she was not instructed to fill out a form requesting release of medical records from the beginning.</p> <p>During an interview on 11/06/2024 at 3:09 p.m., the MR stated she had received the request for release of medical records from Resident #4's responsible party on 10/29/2024. She stated she sent the request to corporate on 10/30/2024. She stated that she had a conversation with the responsible party that it could take up to two weeks before medical records were released. She stated that she thought the facility had 14 days to get medical records to a resident or their representative. She stated she had not gotten approval from corporate to release the medical records and the ADMN would know more about where facility was in releasing records. She stated that if the medical records were large, the family would be asked to pay a fee for those records but denied that she had requested money for medical records at this time.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/2024 at 3:20 p.m., the ADMN stated he believed the facility had 15 days to release medical records based on the Texas Administrative Code. He did not know why the medical records would be denied to a resident's representative. He stated he knew MR had sent a request to corporate but had not been given any information on when the medical records would be released. He stated the resident representative had not been waiting for more than 15 days at this point. He denied any negative impact to the resident or her representative from not receiving medical records.</p> <p>Record review of the facility policy titled Release of Medical Records undated revealed: Request for records should be referred to the Director of Nursing or Administrator, or another staff member previously designated by the facility. Upon request to access or obtain copies of the medical record, the facility should review the authorization to ascertain access rights o that person. Authority to access or release records is only granted by the resident or the resident's legal representative. The facility should request copies of any legal papers necessary to authenticate authority. The legal papers should be attached to the request for records .The corporate office/risk manager should be notified of the request for records. Records should not be released prior to discussion with the corporate office/risk manager, to further validate authenticity of the request. Upon receipt of a request for medical record copies, the facility should notify the requesting party, in writing, of the cost for obtaining records and that records are available 2 days after receipt of payment for the copies. Copies should not be released prior to the receipt of payment for copying charges.</p> <p>Record review of facility policy titled Confidentiality of Personal and Medical Records undated revealed: If there is information considered too confidential to place in the records used by all staff, it may be retained in a secure place in the facility. These confidential records can be formally requested. Once formal request has been received facility staff should gather information requested. The facility has 14 business days to gather requested information. The information will be reviewed at the corporate level before final records will be released to the requesting party. Unauthorized persons are permitted to review records only with the signed permission of the resident or a legal document allowing such assess. Each requested record must be listed on formal document request.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan based on assessed needs with measurable objectives that can be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #1, Resident #2, Resident #3, and Resident #4) of 5 residents reviewed for generic comprehensive person-centered care plans.</p> <p>The facility failed to update care plans with personalized interventions for Resident #1, Resident #2, and Resident #4 in areas such as fall prevention.</p> <p>The facility failed to implement care plan interventions for Resident #3 in areas such as fall prevention.</p> <p>These failures could affect the residents by placing them at risk for not receiving care and services to meet their individual needs.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's electronic face sheet dated 11/02/2024 revealed an [AGE] year-old female admitted to the facility on [DATE] and originally admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, urinary tract infection (infection in the urine), repeated falls, abnormalities of gait and mobility, lack of coordination, and muscle weakness.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed: no BIMS score because the resident was rarely understood. Further review revealed Resident #1 had behavior of wondering, she used wheelchair, she required supervision with eating, she required partial assistance with toileting hygiene, she needed substantial assistance with oral hygiene, showers, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. She had no falls since prior assessment and received SLP and PT.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Comprehensive Care Plan dated 11/05/2024 revealed Focus I am at risk for falling related to repeated falls, poor balance, poor safety awareness, muscle weakness, poor coordination, unstable gait, unaware of limitations. I had an actual fall on 11/2/2024 Goal Resident #1 will remain free from major injury through next review. Interventions: Educate resident to allow staff to pick items up from floor. Date Initiated: 07/03/2023 Revision on: 10/06/2023. Encourage resident to use environmental devices such as hand grips, handrails, etc. PRN Date Initiated: 03/15/2021 Revision on: 10/06/2023 Keep bed in lowest position with brakes locked, call light, personal, and frequently used items within reach at all times. Date Initiated: 02/23/2023 Revision on 10/06/2023. Orient resident when there has been new furniture placement or other changes in environment. Date Initiated: 02/23/2023. Revision on: 10/06/2023. Provide resident an environment free of clutter Date Initiated: 02/23/2023 Revision on 10/06/2023. Provide supervision during showering to minimize risk for falls. Date Initiated: 02/23/2023 Revision on 10/06/2023 Remind resident to remove blankets/items from chairs/recliners and utilize the handrails before going from standing to sitting. Date Initiated: 10/17/2023 Revision on 10/06/2023 Review medications Date Initiated: 03/13/2021 Therapy to complete fall screen and treat if needed. Date Initiated: 03/15/2021 Revision on: 03/22/2021 There was no evidence that care plan interventions had been updated since 10/06/2023.</p> <p>Record review of Resident #1's progress notes dated 10/22/2024 revealed she had been found lying in left side on the floor at bedside. She had spilled her boost drink and reported that she had slipped when trying to get up.</p> <p>Record review of Resident #1's progress notes dated 11/02/2024 revealed she had been found lying on the floor with personal small fridge next to her.</p> <p>Record review of Resident #1's fall investigation tool dated 10/22/2024 revealed recommendations to IDT for fall prevention included resident on therapy, refuses staff help with transfers, continue current interventions, perform urine analysis to follow up once antibiotics had been completed for 72 hours. Fall investigation completed by the DON.</p> <p>Record review of Resident #1's fall investigation tool dated 11/2/2024 revealed recommendations to IDT for fall prevention included continue current therapy. Fall investigation completed by the DON.</p> <p>During an observation and interview on 11/02/2024 at 8:42 a.m., entered the secured unit and no staff members were seen in the hallway. Heard a crash and female voice calling out help me, someone help me. Observed Resident #1 lying on the floor in her room. It appeared that she had knocked the refrigerator over and fell in the process. Two bottled waters seen around the resident and fridge lying to Resident #1's right side. After two minutes, two staff members entered the resident's room and shut her door.</p> <p>During an interview on 11/04/2024 at 2:06 p.m., CNA B stated Resident #1 had not fallen recently. CNA B stated the resident had behavior of putting herself onto the floor and staff would pick her up and put her back into her wheelchair when that happened. CNA B stated Resident #1 usually fell when she had an infection and she needed at least one staff to assist with transfers and showers.</p> <p>During an interview on 11/04/2024 at 2:08 p.m., CNA C stated Resident #1 had not fallen recently. CNA C stated staff watched Resident #1 and assisted her with transfers to help prevent her from falling. CNA C stated Resident #1 would transfer herself when staff were not watching.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/04/2024 at 3:00 p.m., LVN A stated Resident #1 had fallen twice in the last 3 weeks. LVN A stated interventions to prevent falls would be found in the fall risk assessment and care plan, but staff would intervene or assist as needed. LVN A stated prior to Resident #1's fall on 10/22/2024, staff would encourage the resident to use her wheelchair. LVN A stated interventions after the fall included more supervision and more assessments for urinary tract infections because the resident would get them chronically.</p> <p>During a telephone interview on 11/04/2024 at 4:54 p.m., Resident #1's RP stated staff had put Resident #1 in her wheelchair to help prevent her from falling. He stated she was ambulatory most of the time but the ability to ambulate changed when she had a urinary tract infection and staff must focus on her more. He stated she did not suffer injury from falling and to the best of his knowledge she was trying to get something out of her fridge when she fell last. He stated he did attend care plan meetings via telephone and did give his opinion when he felt he needed to.</p> <p>During a telephone interview on 11/05/2024 at 9:19 a.m., the MD stated he was notified of Resident #1's fall. He stated he did get invited to post fall care plan meetings but did not make it to all the care plan meetings. He stated not all care plans needed to be updated and that depends on the resident and their condition. He stated historically Resident #1 falls when she had a urinary tract infection, and he may order for her to have a UA later this week since she just finished treatment for a UTI.</p> <p>Resident #2</p> <p>Record review of Resident #2's electronic face sheet dated 11/04/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: blindness left eye and fall on same level.</p> <p>Record review of Resident #2's admission MDS assessment dated [DATE] revealed: BIMS score of 00 which indicated severe cognitive impairment. Further review of the MDS revealed Resident #2 needed supervision with eating, oral hygiene, and personal hygiene. She needed partial assistance with upper body dressing and substantial assistance with toileting hygiene, showers, lower body dressing, and putting on footwear. Resident #2 did not use walker or wheelchair and received PT, OT, and SLP. Resident had fall prior to admission and fall with injury after admission.</p> <p>Record review of Resident #2's comprehensive care plan dated 11/06/2024 revealed: Focus I am at risk for falls r/t balance problems, confusion, and history of falls. Date Initiated: 10/31/2024 Revision on: 11/06/2024 Goal: My fall risk will be minimized. Date Initiated: 10/31/2024 Target Date 01/20/2025. Interventions: Encouraged me to stay in common areas to promote more supervision Date Initiated 10/31/2024 Encouraged my participation in activities that will increase strength and mobility Date Initiated 10/31/2024 Ensure I am wearing appropriate-fitting clothing and footwear (SPECIFY and describe footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) that fits well when ambulating or mobilizing in w/c . Date Initiated: 10/31/2024. Care plan did not reflect intervention for staff to stop guiding Resident #2 with touch.</p> <p>Record review of Resident #2's progress note dated 10/13/2024 revealed Resident #2 was found on the floor beside her bed. Assessment found hematoma and laceration to right eyebrow.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's fall investigation tool dated 10/13/2024 revealed recommendations to IDT for fall prevention included orientation to location, new admission to facility. Fall investigation completed by the DON.</p> <p>During an observation on 11/04/2024 at 12:22 p.m., Resident #2 was sitting at a dining room table in a dining room chair. Two bruises to her right side of face observed. Resident #2 was feeding self and had slip on shoes that were worn on both feet.</p> <p>During an interview on 11/04/2024 at 2:06 p.m., CNA B stated interventions in place to prevent falls included keeping a close eye on Resident #2. CNA B stated Resident #2 would start screaming and hollering if staff attempted to assist her. CNA B stated staff would let Resident #2 calm down and attempt to assist her again after she had calmed down.</p> <p>During an interview on 11/04/2024 at 3:00 p.m., LVN A stated staff knew that interventions to prevent falls would be found in the fall risk assessment and care plan, but staff would intervene or assist as needed. LVN A stated Resident #2 had fallen about a month ago and had been sent to the ER following the fall. LVN A stated Resident #2 had stitches to her right temple area at the ER. LVN A stated prior to the fall there were no interventions in place. LVN A stated the facility staff were still trying to learn Resident #2 at that time and Resident #2 would freak out, shook, and got more unsteady if staff attempted to guide her with touch. LVN A stated that new interventions put in place after the fall included for staff to stop guiding Resident #2 with touch.</p> <p>During a telephone interview on 11/04/2024 at 5:20 p.m., Resident #2's RP stated she had not been invited to any care plan meetings. She stated she and family member were notified of Resident #2 falling and went with her to the ER. She stated she was unaware of what the facility was doing to prevent Resident #2 from falling. She stated she felt anxiety may have played a role in the resident falling and voiced concerns that the secured unit did not have staff stationed at both ends of the hall. She stated Resident #2 did get dizzy when standing up at times.</p> <p>During a telephone interview on 11/05/2024 at 9:19 a.m., the MD stated he was notified of the fall Resident #2 had on 10/13/2024. He stated one reason she had falls was due to being on benzodiazepines for anxiety. He stated the medication treated her anxiety but did increase her risk for falls. He stated he had not changed any of her medications because Resident #2 was on a low dose of antianxiety medication and anxiety could lead her to falling also.</p> <p>During a telephone interview on 11/05/2024 at 9:56 a.m., Physician D stated he would not know if Resident #2 had a fall on 10/13/2024 because his nurses handled that information. He stated he did not expect to be invited to care plan meetings and was not sure if the resident's family was invited to care plan meetings. He stated the care plan probably needed to be updated after a resident had a fall but there was no good way to prevent falls in patients with dementia and stated Resident #2 had dementia. Physician D stated Resident #2 had fallen for different reasons and would fall even if staff were walking next to her.</p> <p>During an interview on 11/06/2024 at 4:25 p.m., the DON stated care plan interventions (SPECIFIC) did not need to be filled in. She stated she would just remove that verbiage if she was doing a care plan. She stated there basically was non-skid socks and shoes that were standard for every resident. She stated she did not believe the area needed to be filled in with more specific information. She did not feel that not filling in that area caused any negative effect on Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #3</p> <p>Record review of Resident #3's electronic face sheet dated 11/04/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease.</p> <p>Record review of Resident #3's quarterly MDS dated [DATE] revealed: no BIMS assessment score because the resident was rarely understood. Further review of the MDS revealed Resident #3 needed setup assistance with eating. She needed supervision with oral hygiene and toileting. She needed partial assistance with upper body dressing, lower body dressing putting on footwear, and personal hygiene. Resident #3 was dependent on staff for shower. Resident #3 used no walker or wheelchair. She frequently was incontinent of urine and bowel. She took anticoagulant medications. Resident #3 did not receive therapy.</p> <p>Record review of Resident #3's care plan dated 11/04/2024 revealed Focus: Potential for injury R/T [x] Actual falls [x] HX of falls and is at risk for further falls R/T: [x]cognitive impairment D/T short term memory deficit [x] impaired safety awareness Date Initiated: 06/13/2024 Revision on 06/13/2024; Goal Goal [x] I will have decrease in the # of fall events through the next review date. Date Initiated: 06/13/2024 Revision on: 06/13/2024 Target Date: 12/30/2024; Interventions: Ensure staff aware of safety needs of the resident Date Initiated: 06/13/2024 Provide proper, well-maintained footwear Date Initiated: 06/13/2024 Provide resident an environment free of clutter Date Initiated: 06/13/2024. No evidence that care plan interventions had been updated since 06/13/2024 for fall prevention. Care plan did not include intervention to physically guide her or frequent toileting.</p> <p>Record review of Resident #3's progress notes dated 08/16/2024 revealed Resident #3 was ambulating in the hall and fell on to the left side hitting her left posterior scalp, left shoulder, and left knee. Nurse observed fall and resident reported I got dizzy.</p> <p>During an observation on 11/04/2024 at 12:13 p.m., Resident #3 was sitting at dining room table with socks on and no shoes. The socks did not have slip resistant grips on them.</p> <p>During a telephone interview on 11/04/2024 at 8:04 p.m., Resident #3's RP stated that he was notified of fall, and he did get invited to care plan meetings. He stated he will join via telephone and did give his input. He stated her dementia and bad knee was what he felt caused the fall. He stated no concerns with how the facility cared for Resident #3.</p> <p>During an interview on 11/04/2024 at 2:06 pm, CNA B stated Resident #3 had not fallen on their shift. CNA B stated the resident was very confused and roamed in and out of rooms. CNA B stated staff tried to keep Resident #3 in the main areas to help prevent her roaming and decrease fall risk by more supervision.</p> <p>During an interview on 11/04/2024 at 3:00 p.m., LVN A stated Resident #3 had fallen on their shift, and they observed the fall. LVN A stated Resident #3 had been ambulating in the hall towards the dining area when she got weak and fell hitting her arm on the railing. LVN A stated they attempted to get to Resident #3 but could not reach her in time before she fell . LVN A stated interventions prior to Resident #3 were to physically guide her places, and frequent toileting to help prevent Resident #3 from using the restroom anywhere when the urge occurred. LVN A stated that after recent fall, interventions included more frequently toileting resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 11/05/2024 at 9:19 a.m., the MD stated he had been notified of Resident #3's fall on 08/16/2024. He stated he had addressed her dizziness and nausea which he felt led to the fall. He stated she had low blood pressure on 08/27/2024 and medications were addressed.</p> <p>During an interview on 11/05/2024 at 2:21 pm, the DON stated that Resident #3's risk factors for a fall were evaluated quarterly and upon an event. She stated the last fall Resident #3 had, was on 08/16/2024. The DON stated Resident #3 had gotten dizzy and the facility sent her to the ER for an evaluation. The DON stated no fractures had occurred but was diagnosed with elbow contusion (deep bruise) in the ER and was sent back to the facility with an order to give over the counter pain medication. She stated interventions prior to the fall were for staff to maintain needs, proper footwear to be worn, and keep the environment free of clutter. She stated no new interventions were added to the care plan after the fall. She stated Resident #3 was tested for urinary tract infection in the ER and was treated for infection in the hospital.</p> <p>Resident #4</p> <p>Record review of Resident #4's electronic face sheet dated 11/02/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: dementia, muscle weakness, unsteadiness on feet, lack of coordination, history of falling, age-related physical debility, and macular degeneration (impaired vision).</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed: BIMS score of 02 which indicated severe cognitive impairment. Further review of MDS assessment revealed the resident needed set up assistance with oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. Resident #4 needed supervision assistance with eating, showering, and lower body dressing. Resident #4 needed partial assistance with putting on and taking off footwear. She used a walker and had no rejection of care behaviors. She had occasional urinary incontinence and was always incontinent to bowel. She had 3 falls, with minor injury with 2 falls.</p> <p>Record review of Resident #4's care plan dated 08/08/2024 revealed she was risk for falls related to balance problems, confusion, deconditioning, gait problems, and history of falls. The goal was for fall risk will be minimized. The interventions listed were Encourage me to stay in common areas to promote more supervision .Encourage my participation in activities that will increase strength and mobility. Further review of care plan revealed no evidence that the care plan was updated after 08/08/2024 and did not include the interventions of: placing a mattress on the floor, therapy, or change in ambulation from walker to wheelchair.</p> <p>Record review of Resident #4's progress notes dated 08/13/2024 revealed Resident #4 fell in the hallway and was witnessed by 2 staff.</p> <p>Record review of Resident #4's progress notes dated 08/28/2024 revealed Resident #4 was found on the floor of her bathroom.</p> <p>Record review of Resident #4's progress notes dated 09/07/2024 revealed Resident #4 was lying on the floor on her right side.</p> <p>Record review of Resident #4's progress noted dated 09/14/2024 revealed Resident #4 was lying on the floor leaning on her left side and had blood on the right side of her face and in hair.</p> <p>(continued on next page)</p>		

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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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's fall investigation tool dated 09/07/2024 revealed recommendation to IDT for fall prevention were for frequent reminders and to continue current interventions.</p> <p>Record review of Resident #4's fall investigation tool dated 09/14/2024 revealed recommendation to IDT for fall prevention were for increased frequency of checks and family wanted a camera in her room but have not provided a camera.</p> <p>During a telephone interview on 11/04/2024 at 12:43 p.m., Resident #4's RP stated she did get invited to care plan meetings. She stated Resident #4 was using a walker until July of 2024 then she was changed to a wheelchair. Resident #4's RP stated her opinions were not gathered during care plan meetings and staff just discussed what was going on with Resident #4. She did not know of any other interventions that had changed to help prevent Resident #4 from falling. She stated Resident #4 did go on hospice services in September and in September both her and another family member saw Resident #4 lying on the floor next to a mattress that was lying beside her bed.</p> <p>During an interview on 11/04/2024 at 2:06 p.m., CNA B stated Resident #4 never fell during their shift. CNA B stated staff put a mattress on the floor beside her bed and would put her in her wheelchair to help keep her from falling when she did not use a walker anymore. CNA B stated Resident #4 had a lot of swelling in her hands that was new and swelling in her legs that was not new. CNA B stated the resident did refuse showers at times and staff would let her calm down and ask her again to get her to take showers.</p> <p>During an interview on 11/04/2024 at 2:08 p.m., NA C stated Resident #4 had gotten more confused and after staff laid her down, she would try to get up on her own. NA C stated Resident #4 had behaviors of taking her clothes off and moving clothes around. NA C stated staff put Resident #4's bed in low position but she was able to get the remote and use it to raise the bed up. NA C stated staff put a mattress beside Resident #4's bed to help prevent falls. NA C stated Resident #4 would refuse showers and staff would circle back around and offer again and she would change her mind sometimes.</p> <p>During an interview on 11/04/2024 at 3:00 p.m., LVN A stated interventions to prevent falls included toileting often because Resident #4 would try to toilet without assistance. LVN A stated Resident #4 had a will to do things without assistance and did not like to be touched. LVN A stated interventions after falls included a mat at her bedside.</p> <p>During a telephone interview on 11/05/2024 at 9:19 a.m., the MD stated he had been notified of Resident #4's falls. He stated he believed one of the reasons she had been falling was because of the edema to her legs that was being addressed. He stated the fall on September 14th with bruising and swelling around nasal bone did not warrant ER evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/05/2024 at 2:21 p.m., the DON stated Resident #4's risk factors for falling were dementia, deconditioning, gait imbalance, and medication use. She stated risk factors were assessed quarterly and upon an incident. The DON stated interventions in place prior to August 13th fall were for encouragement to remain in common areas, and to use wheelchair and therapy services. She stated interventions in place prior to August 28th fall was for therapy services, encouragement to remain in common areas, and use of wheelchair. She stated interventions after falling included therapy and Resident #4 started therapy services on [DATE]th and remained on therapy for the remainder of time she was at the facility. She stated after August 28th fall new interventions included continuous reminder to use wheelchair and reiterating what therapy was enforcing. The DON stated after September 7th fall interventions included continue on therapy services and reminders to use wheelchair. She stated after September 14th fall new interventions of non-skid footwear and continue on therapy was listed in progress notes. She stated every staff that had access to care plan had access to progress notes and progress notes were where staff could find those interventions. She stated nurses and CNAs were notified of interventions verbally during shift report from staff that were leaving. She stated her expectation would be for new interventions to be added into the care plan. She denied any negative outcome occurred to residents due to staff able to find information in progress notes rather than reference care plan. She stated she did not know why interventions were not added into the care plan. She stated she did write important care items on a daily sheet that was kept at the nurses' station after the IDT has morning meetings to help pass along information. She stated she leaves sheets for the night shift at the nurses' station as well.</p> <p>During an interview on 11/05/2024 at 3:40 p.m., the ADMN stated the facility had identified that the care plans needed work. He stated the DON and a remote MDS nurse were working on the care plans. He stated the facility had just hired a new onsite MDS nurse that will start working on updating care plans. He expected for care plans to be up to date with current interventions and the MDS nurse was to bring a laptop to morning meetings to start updating care plans. He expected for charge nurses to relay information to nurse assistants so that staff would know what interventions to do to take care of residents. He stated staff were able to perform emergency interventions but would expect placing a mattress on the floor to be in the care plan. Admn would not stated how the failure could affect the residents.</p> <p>During a follow up interview on 11/06/2024 at 4:20 p.m., the DON stated she expected to be notified if staff were using a mattress on the floor beside the bed as fall prevention intervention. She stated the care plan should have been updated with such an intervention. She agreed that mattress on the floor was better than Resident #4 falling but she was not aware of staff doing so. She denied any negative outcome occurred to residents due to staff able to find information in progress notes rather than reference care plan.</p> <p>Review of facility's policy titled Fall Prevention Program dated 07/01/2022 revealed Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy titled Comprehensive Care Plans dated 07/2023 revealed The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed .The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment .f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883</p> <p>Based on observations, interviews, and record review the facility failed to ensure a resident received proper treatment and care to maintain mobility and good foot health, and provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and assist the resident in making appointments with a qualified person for 1 of 5 residents (Resident #4) reviewed for quality of care.</p> <p>Resident #4 did not see a podiatrist despite having thickened and long toenails and the request of the resident's RP.</p> <p>This failure could place residents at risk of pain, toenail injury, difficulty wearing socks and or shoes, and could result in embarrassment, frustration, anxiety, and a decreased quality of life.</p> <p>The findings were:</p> <p>Record review of Resident #4's electronic face sheet dated 11/02/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: dementia, muscle weakness, unsteadiness on feet, lack of coordination, history of falling, age-related physical debility, and macular degeneration (impaired vision). Further review revealed Resident #4 was discharged from facility on 09/27/2024.</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed: BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS assessment revealed the resident needed set up assistance with oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. Resident #4 needed supervision assistance with eating, showering, and lower body dressing. Resident #4 needed partial assistance with putting on and taking off footwear. She used a walker and had no rejection of care behaviors. She had occasional urinary incontinence and was always incontinent to bowel. She had 3 falls with minor injury, with 2 falls.</p> <p>Record review of Resident #4's care plan dated 08/08/2024 revealed no mention of podiatry services or of thickened and long toenails.</p> <p>Record review of Resident #4's electronic physician orders with revision date of 12/18/2023 revealed May be seen by Podiatrist as needed.</p> <p>Record review of Resident #4's shower sheets revealed long nails documented on September 27, 2024, September 6, 2024, September 2, 2024, August 26, 2024, August 19, 2024, August 31, 2024, July 24, 2024, July 22, 2024, July 19, 2024, July 17, 2024, July 12, 2024, July 10, 2024, July 3, 2024, July 1, 2024, June 26, 2024, June 21, 2024, June 17, 2024, June 7, 2024, June 3, 2024, May, 15, 2024, May 10, 2024, May 6, 2024, and May 1, 2024. Further reviewed of shower sheets revealed on August 7, 2024, refused emery board, and refused nail/toenail care, and refused nail care on June 17, 2024, June 12, 2024, and June 3, 2024.</p> <p>Record review of Resident #4's EHR revealed no documentation, appointments, or recommendations for Podiatry or toenail trimming or general foot and nail care .</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/04/2024 at 12:43 p.m., Resident #4's RP stated that she was told by the SW, the facility podiatrist would see Resident #4 sometime around February 29th, 2024. Resident #4's RP stated she was never told after that if Resident #4 had been seen by podiatrist, but her toenails never got cut. She said she was upset that Resident #4's nails were thick and long. RP said she felt Resident #4 lost her toenail because her toenails were long and may have gotten caught on something.</p> <p>During an interview on 11/06/2024 at 9:09 a.m., NA E stated NAs were allowed to perform toenail care if the resident's toenails were not complicated or the residents did not have diabetes. NA E stated the last day they took care of Resident #4, her great toenail on one of her feet had been cracked but did not remember for sure. NA E stated they circled the area on the shower sheet when nail issues observed so that the charge nurse and wound care nurse would be notified. NA E stated Resident #4's toenails were complicated, and they were not able to perform foot care on her.</p> <p>During an interview on 11/06/2024 at 9:34 a.m., the SW stated she went around the whole building and asked residents if they wanted a podiatry visit. The SW stated she would make a list of residents that needed to be seen by podiatry based on residents wants and needs voiced by nurses and family. She stated the list was separated up by halls and the podiatrist would go see those residents and his wife would document if a resident refused podiatry services. She stated she would document in EHR the visit or the refusal after the podiatrist finished seeing residents. She stated if a resident refused the podiatry, the podiatrist would attempt to see that resident again in 3 months. She stated she would look through Resident #4's EHR and see if there was documentation of podiatry visit or refusal.</p> <p>During an interview on 11/06/2024 at 10:03 a.m., LVN F stated Resident #4's RP mentioned toenails needed to be cut but Resident #4 would not let staff or family cut her nails. LVN F stated the podiatrist came to the building about every 3 months. She stated she would notify the SW if a resident needed podiatry services. LVN F stated she had attempted to perform foot care by using emery board to file down toenails but Resident #4 would pull away and say, no don't. LVN F stated Resident #4 was agitated after the attempt. She had no knowledge of any toenails being missing.</p> <p>During an interview on 11/06/2024 at 11:03 a.m., the MR stated she would upload documents into the EHR after receiving them. She stated there were no outstanding podiatry visit notes that needed to be uploaded into the EHR system.</p> <p>During an interview on 11/06/2024 at 11:17 a.m., the DON stated she expected for podiatry visits to be provided to residents who needed podiatry and that staff were unable to provide foot care for. She stated the SW would refer to the podiatrist when foot care was needed. She stated she was looking for podiatry notes or documentation about Resident #4 but could not provide anything at this time.</p> <p>During an interview on 11/06/2024 at 1:59 p.m., LVN G stated she had witnessed attempted foot care to Resident #4. She stated Resident #4 would slap and attempt to pinch staff when trying to do fingernail care. She stated Resident #4 would try to kick staff and pull away when attempting to perform toenail care.</p> <p>During a follow up interview on 11/06/2024 at 3:04 p.m., the SW stated she had not been able to locate documentation on Podiatry visit notes for Resident #4 .</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During exit conference, the facility was not able to provide any documented podiatry visit notes on Resident #4.</p> <p>Record review of the facility policy titled Podiatry Services with no date revealed: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health .Foot care that is provided in the facility, such as toe nail clipping for residents without complicating disease processes, should be provided by staff who have received education and training to provide this service. Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as a Podiatrist, Doctor of Medicine, and/or Doctor of Osteopathy. Foot disorders which may require treatment include, but are not limited to: corns, neuromas, calluses, hallux valgus (bunions), digiti flexus (hammertoe), heel spurs, and nail disorders. Employees should refer any identified need for foot care to the social worker or designee. The social worker or designee will assist residents in making appointments and arranging transportation to obtain needed services.</p>		