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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure residents were free from neglect for 1 of 7 (Resident $1) reviewed for neglect in that: The facility staff neglected Resident #1 when staff identified Resident #1 as having a cut to the right side of his head after an unwitnessed fall on [DATE], and did not communicate with the nurse to assess resident and begin doing neurological assessments a subdural hematoma (brain bleed) and death on [DATE]. An Immediate Jeopardy (IJ) situation was identified on 8.28.25. The IJ template was provided to the facility on 8.28.25 at 3:05 pm. While the IJ was removed on 8.29.25, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of isolated, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures could put residents at risk of not being provided services/care while in the facility. The findings included: Record review of Resident #1 face sheet he was a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #1’s diagnoses included encephalopathy (a condition in which the brain does not function properly), dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), depression and hypertension. Resident # 1’s BIMS score was 5, indicating severe cognitive impairment. Record review of Resident #1’s care plan dated 8.22.25 indicated: The resident is high risk for falls. Res has spontaneous behaviors and attempts to self-transfer. The resident will be free of falls through the review date. The resident will not sustain serious injury through the review date. 6/19- actual fall, nonskid footwear. 7/5- actual fall, frequent reminders to use call light. 8/13- actual fall, visual reminder in the bathroom. 8/15- actual fall, visual reminder in room. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Encourage resident to ask for assistance with all transfers. Bleeding was also notated in care plan, linked below. Eliquis was not directly named in care plan. Risk for Bleeding Date Initiated: [DATE], Resident Will Be Free of Falls Date Initiated: [DATE], Target Date: [DATE], Resident Will Show No Signs/Symptoms of Bleeding Date Initiated: [DATE] Target Date: [DATE], Avoid unnecessary invasive procedures, punctures or injections Date Initiated: [DATE], Evaluate blood pressure, Date Initiated: [DATE], Evaluate fall risk on admission and PRN Date Initiated: [DATE], Evaluate for blood in stools, Date Initiated: [DATE], Evaluate for change in level of consciousness, Date Initiated: [DATE], Evaluate for hematemesis (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676416	A. Building B. Wing	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date Initiated: [DATE], Evaluate for hematuria, Date Initiated: [DATE], Evaluate heart rate, Date Initiated: [DATE], Evaluate skin for evidence of impaired coagulation (bruising, petechia, bleeding from orifice), Date Initiated: [DATE], If fall occurs, alert provider, Date Initiated: [DATE]. Record review of Resident #1 pharmacy orders indicated Eliquis 5mg (blood thinner used to reduce risk of stroke and blood clots): Give 1 tablet by mouth two times a day related to unspecified atrial fibrillation. Record review of Resident #2’s quarterly MDS assessment dated 8.22.25 revealed a 15 BIMS score was noted but was marked as no impaired under the cognitive skills for daily decision making. During interview on 8.27.25 at 10:15 AM physician A (Hospital ER MD) stated that based on the injury and the combination of Resident #1 being [AGE] years old and on 5mg of Eliquis, along with a cut to the right side of the head reported by family as occurring on Monday [DATE] started the bleed. She stated when she saw the resident in the ER on Wednesday [DATE], he had a small scratch/cut on the top right side of the head. She stated due to Resident #1 being on a blood thinner, and the fact that there was a head injury even anything as minor as a scratch/cut can be an indication of a brain bleed. The resident should have had continued monitoring, even if there was 1 good neurological check, would not mean there was no brain bleed. Often with a blood thinner of any type, there would be a bleed that would not be immediately noticed, and a resident could be talking with you fine at times, then symptoms could be increased tiredness and lethargy. She stated by the time Resident #1 was seen in the ER on [DATE] the bleed was too significant and could not be fixed. She stated this was the resulting factor that caused Resident #1 to pass away on [DATE]. During an interview on 8.22.25 at 10:05 AM Resident #1’s family member stated that on [DATE] she was at the facility and Resident #1 had a fall in his shower. She stated Resident #1 sustained a cut to his right elbow and the top right side of his head. She said he had passed away the morning of [DATE]. She stated that she heard a CNA C tell Resident #1 not to get up off the toilet, she was going to go grab a towel or something. She stated next thing she knew Resident #1 was found on the floor of the shower. She stated a CNA C came to the room that day to get Resident #1 up and into the restroom. She stated she heard CNA C tell Resident #1 do not get up or move from the toilet she had to go get something. She stated that when the CNA came back in, Resident #1 was on the floor in the shower. She stated that not only did CAN A help the resident up but also the RN B came to the room to assess and help the resident up. During an interview on 8.22.25 at 11:15 AM CNA A stated she did notice a scratch/cut approx. 1 inch long to the top right of Resident #1’s head in the afternoon on [DATE]. She stated she was not sure exactly where the cut came from. She stated it could have come from anywhere, so she did not notify anyone of the injury. She stated that on 8.19.25 Resident #1 stayed in bed most of the day and was very lethargic, not acting like himself but she didn’t tell anyone. She stated normally when there was a new injury to a resident, she would let the charge nurse know, but this was so minor of a scratch she did not feel she needed to. CNA A stated she never help Resident #1 up from any fall on 8.18.25, only that she noticed a small scratch to the right side of Resident #1’s head. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8.22.25 at 3:05 PM CNA C stated that he noticed that Resident #1 was not himself during the afternoon on Tuesday [DATE]. He stated that normally Resident #1 would hold his hand and try to hug him. He stated Resident #1 did not try any of his normal behaviors and was lethargic as he laid in bed most of the day. CNA C thought he was just tired and didn’t tell the nurse or other nurse aides. CNA C observed the bandage on the top right side of Resident #1’s scalp, but did not have any knowledge of the head injury occurrence from [DATE]. CNA C normally when an injury was observed on a resident, he would let his charge nurse know or at least let the next shift know during shift change, but CNA C did not because the injury was not that large. During an interview on 8.22.25 at 3:15 PM PT D and PT E both stated that they went to Resident #1’s room around 7:35 am on [DATE] to get Resident #1 up for PT. They both stated he would not respond to sternum rub (a medical procedure used to assess a patient's level of consciousness and responsiveness), and they noticed blood around Resident #1’s mouth. They called in the nurse and Resident was sent out to local hospital roughly around 7:55 am by EMS. During an interview on 8.22.25 at 3:45 pm Resident #2 (the roommate of Resident #1) stated he did observe a new cut on the top right side of Resident #1’s head, later in the day on [DATE] around dinner time. Resident # 2’s BIMS score was 15, indicating no cognitive impairment. During an interview on 8.22.25 at 3:45 pm Resident #2 (the roommate of Resident #1) stated he did observe a new cut on the top right side of Resident #1’s head, later in the day on [DATE] around dinner time. During an interview on 8.22.25 at 12:15 PM RN B stated while he was helping Resident #1 off the toilet on [DATE], Resident #1 and his family member told him about a fall on [DATE]. Resident had a cut approximately ¾ to 1 inch on the top right side of his head and on his right arm. RN B put bandages on both. He stated that it was an unwitnessed fall that he charted in his incident report on [DATE]. He stated that due to Resident #1 passing Neuro assessment at that time he did not start Neuro checks. RN B stated that he did not relay the injury to other staff afterwards. RN B stated he was aware that Resident #1 was on Eliquis, that was a blood thinner, however the 1 neuro assessment he did at the time, the resident eyes were not dilated, he could speak to him with memories from the previous day, so Resident #1 passed the neuro check. RN B stated normally when a Resident has a fall with head injury or if the resident hit their head, neuro checks/rounding would be initiated and done for 72 hours. RN B stated he did call the physician the day that he was informed to do an incident report on the fall, which was dated 8.19.25. During interview on 8.29.25 at 3:45 pm Physician B stated that, “yes there was a quapi meeting this morning associated to abuse neglect, non-reporting/communication and neuro checks. He stated was happy with the facility and all the protocols put in place to correct the IJ;s. he stated he had no other concerns with the facility. he did get notified about Resident #1’s fall but could not give the exact date. He stated that any resident that was on a blood thinner he would review before giving the facility the go ahead on what to do. He stated he did not have any concerns with the resident the day he received the call from the facility regarding the fall and the resident being on a blood thinner.” (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8.25.25 at 12:25 AM the DON indicated on [DATE] that due to state being in the building on [DATE], she asked RN B if anything happened to Resident #1. She stated RN B stated to her that Resident #1 did sustain an unwitnessed fall in the bathroom on [DATE]. She stated she told him to get his incident report completed immediately on the incident. She stated no other communication was done by RN B regarding the incident. She stated no continuous Neuro checks were completed. The DON stated that because there was 1 neuro check and resident was fine on [DATE], there was no need to monitor further. The DON stated her expectation was even with a head injury or unwitnessed fall, if a resident could pass 1 neuro assessment, there would be no need to have continuous monitoring. The DON stated she knew Resident #1 was on blood thinners but due to how minor the scratch was she did not believe neuro rounding was needed. Incident report on Resident #1, dated [DATE], as a late entry for [DATE] Injury type abrasion location top of scalp. no documentation of physician notification and no documentation of Resident #1’s increased lethargy and change in behavior on [DATE] and [DATE]. No measurement of abrasion/scratch to the top of right side of head completed. Review of Resident #1’s hospital records included: CT scan [DATE] was a Large right subdural hematoma (brain bleed) along the entire convexity from anterior-posterior midline measuring up to mostly 15mm in thickness. The result was a midline shift (brain tissue moved) to the left of about 7mm. While in ER on [DATE] Resident #1 had 30-45 second full tonic colonic seizure. ER diagnosis dated 8.20.25 was a Nonsurvivable head bleed. [DATE] Resident #1 passed away at the hospital. Record review of facility policy titled Abuse, neglect, Exploitation and Misappropriation prevention program dated [DATE] indicated: resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents’ symptoms. Record review of facility policy titled Neurological assessment dated [DATE] indicated: The purpose of this procedure is to provide guidelines for conducting a neurological assessment (“neuro checks”) on resident with knowns or suspect head trauma or acute changes in mental or motor function that may be indicative of a neurological event. 13. Neurological checks will be initiated at time of incident-unwitnessed fall or head injury for 72 hours and as ordered by the physician/physician extender. Record review of facility policy titled Assessing Falls and their Causes dated 2021 indicated: Steps in the Procedure After a Fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. 5. Notify the resident’s attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. b. When fall does not result in significant injury or a condition change, notify the practitioner routinely (e.g., by fax or by phone the next office day). 6. Observe for delayed complications of a fall for approximately seventy-two (72) hours after an observed or suspected fall and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 8. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed in the electronic health record by the charge nurse on duty at the time. Record review of facility policy titled Falls-Clinical protocol dated 2021 indicated: Monitoring and following up-1. The staff, with the physician’s guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. This was determined to be an Immediate Jeopardy (IJ) on 8.28.25 at 3:05 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 8.28.25 at 3:05 pm. Record review of Plan of Removal accepted on 8.29.25 at 12:45 PM reflected the following: F600 Neglect (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Plan to Remove Immediate Jeopardy Please accept the following Plan of Removal of Immediate Jeopardy-F600- Failure to ensure residents are free from abuse/neglect/exploitation. 1. On [DATE] at 1510 The facility RN B was suspended immediately pending investigation, by the administrator. This investigation will be completed by [DATE]. 2. All current staff were in-serviced on abuse and neglect and reporting abuse or neglect policy and procedures by the Director of Nursing on [DATE]. For those on who cannot be reached, by phone will not return to work without receiving this in-service. Staff will be questioned, 3 random staff members, three times a week for 4 weeks to ensure comprehension. 3. The director of nursing was educated on the neurological policy on [DATE] by the VP of Clinical Services. The Director of Nurses was educated by the VP of Clinical Operations, related to the policy stating that neuro checks will be initiated upon any unwitnessed fall or fall with head injury, to continue X72 hours or unless otherwise indicated. 4. All current nursing staff were in-serviced on documentation of Unwitnessed falls and Neuro Check Policy by the Director of Nursing On [DATE]. For those on who cannot be reached by phone, will not return to work without receiving this in-service. Staff will be questioned, 3 random staff members, three times a week for 4 weeks to ensure comprehension. 5. RN B Will complete all in-services 1:1 with the DON if allowed to return work with residents, by [DATE]. 6. The Administrator/Designee is responsible for ensuring that all assigned in-service for abuse and neglect is completed by all staff members, by [DATE]. Completion will be reviewed at monthly QAPI meetings. 7. DON is responsible for ensuring that all assigned nursing in-service are completed on [DATE]. For those on who cannot be reached by phone, will not return to work without receiving this in-service prior to anyone working. The administrator will review any new staff to ensure in-services are completed, prior to their first shift on the floor. 8. DON reviewed all other 14 residents on anticoagulants for falls and neuro check documentation on [DATE]. No further injuries were noted on any residents. 9. Social worker completed Safe Surveys on the other 51 interview able residents to ensure they feel safe and free from abuse and neglect. This was completed on [DATE]. No residents reported signs of Abuse or Neglect. 10. Any staff member suspected of committing abuse/neglect will be suspended immediately and/or terminated depending on the outcome of the investigation. 11. Staff who fail to report suspected abuse and change in condition will be educated on the significance of reporting time and disciplined accordingly. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12. Starting [DATE] DON/Designee will conduct random questioning on 3 staff members daily for 4 weeks for staff to ensure they are understanding and retaining the education on abuse and neglect and reporting procedures. 13. Results from random staff questioning will be reviewed during the monthly QAPI meetings with DON, Administrator, and Medical Director. Any incorrect answers will be corrected immediately. Progress will also be monitored during weekly Committee Meetings and Medical Director will be notified of all progress. Monitoring and verification of the facility POR as follows: During a phone interview on 8.29.25 at 11:15 AM Phone interview LVN F work nights-6pm shift yesterday-She stated that she did 4 in-services total yesterday before she was allowed to work. She stated the main one that stands out was falls with head injuries. She stated any fall with a head injuria, an incident report must be completed. She stated that they will no longer use paper copies to do neuro checks but to use the pcc system to get them completed. She stated that neuros must be initiated on all unwitnessed falls, falls in which residents are on anti-coagulants, contact family, don, physician, and administrator. She stated that documentation went hand in hand with the in-services regarding the falls and injuries, and neuros. She stated that that abuse neglect, anything seen or suspected was to be reported to the administrator immediately. She stated that all in-serves were led by the DON. She stated there was a small recall/quiz at the end with information services. During a phone interview on 8.29.25 at 11:30 AM Phone interview LVN G stated there were 4 total in-services. She stated abuse/neglect, documentation, neuros, and falls w/ head injury. She stated that abuse neglect was nothing crazy new. She stated that if you suspect any abuse neglect or witness any sort of abuse neglect let the administrator know and let the don know, the physician and family. She stated documentation wise most importantly was to get the incident report done immediately and to inform all parties about that incident that occurred. She stated for example any resident with a fall that was on an anti-coagulant was to be sent out of the facility via to the ER. She stated then all documentation must be filled out and neuros starts if resident was not on any anti coagulants. She stated neuros really need to be started on all unwitnessed falls and all falls that include head injury that were witnessed. She stated at the end of each in-service there was a recall of knowledge quiz a question-and-answer time for any issues. She stated it was good to hear everything and have the review. During a phone interview on 8.29.25 at 11:45 AM Phone interview CNA H stated that before she was allowed to start work last night at 6pm there were 4 in-services that were completed. She stated that documentation, which was a little more in depth for the nursing side but documentation anytime any abuse/neglect or fall or anything happens in the facility she was to make sure all statements were complete and to always follow her chain of command. She stated that any time abuse or neglect was witnessed, or any sort of injury was seen to be new on a resident, she was to report to her charge nurse. She stated if she were to observe a fall, she would get the charge nurse or get help while another cna stayed with the resident. She stated at the end of the in-services there was a recall of all information that was covered and then a question and answer if any questions. She stated she appreciated her facility going over everything and it was a lot of good information. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 8.29.25 at 12:00 PM Phone interview CNA I stated that there were 4 in-services she had to complete before she was allowed to work last night. She stated that 3 were more to both types of staff while the 4th in-service was more for nursing staff. She stated abuse neglect, to make sure anytime she was to witness any type of abuse/neglect it was to be reported to her chain of command. She stated she would let her nurse/charge nurse know but knows the abuse coordinator was the administrator. She stated when it came to falls, anytime a resident was observed falling or found on the ground she was to report/call for help to have the nurse come and assess the resident. She stated she was not to touch or move the resident in any, way, but only to make sure to get help for the resident and for a nurse to come and assess the resident. She stated neuros were covered but that was more for nurses and not CAN’s. she stated lastly, they covered documentation, again more towards nursing but also if anything abuse/neglect, injury, or fall were observed she would need to document everything and then use the chain of command to communicate everything that she observed. She stated at the end there was a question and answer and then a recall session of the in-services to test retention of education. During a phone interview on 8.29.25 at 12:45 PM Phone interview CNA J stated she was in-service las night before she was allowed to work. She stated due to being a CAN’s she was not allowed to assess any resident given any fall or found on he ground. She stated she was to reach out to the charge nurse or any nurse to come do an assessment on the resident. She stated any new injuries should be identified and communicated to the nurse as soon as possible so that the nurse could notate any changes to the resident or their behavior. She stated that any signs or physically saw abuse of any kind should be reported to the administrator immediately. She stated any changes in condition, if the resident were acting different in anyway should be reported to the nurse. She stated overall all of the in-services had to do with reporting to the nurses, what to report, how to report and to make sure to follow the chain of command. During a phone interview on 8.29.25 at 1:30 pm LVN K stated that there were 4 in-services that she had to complete before she was allowed to work this morning. She stated the main in-service for nursing was the combination of documentation, falls, anticoagulants, and neuro rounding. She stated that the main thing with documentation was that all neuro rounding would be completed in the electronic system and not a paper trail. She stated she believes the facility will honestly use both to make sure everything was completed and accurately. She stated for example if a resident who was on an anti-coagulant has a fall that was unwitnessed the resident will be sent to the ER no questions asked. She stated that but if the fall was witnessed and the resident was not on anti-coagulants then neuro rounding would be triggered, and the resident would be rounded on for a minimum of 72 hours. She stated that abuse neglect in service was very straight forward, what to look for, who to report to (administrator), that sort of thing. She stated but the importance of any head injury with fall with a resident who was on anticoagulants must been sent out or monitored properly. She stated at the end of the in-services there was a recall of knowledge. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 8.29.25 at 1:45 PM LVN L stated there were 4 in-services that she had to complete before she was allowed to start working this morning. She stated that abuse/neglect was one of the very normal abuse/neglects in-services that went over what constitutes abuse neglect, who to report to, how to report and what you are looking for that constitute abuse and neglect. She stated the other 3 in services for the nurses in the building all flowed into each other. She stated the in-services covered documentation, falls, and neuro checks. She stated that if any resident who was on anti-coagulants has an unwitnessed fall the resident was to be sent out immediately. She stated but if a resident has a fall and head injury was suspected and not on anti-coagulant then neuro founding would need to be initiated. She stated all documentation would need to be filled out immediately and neuro checks initiated in the electronic nursing system. She stated that after the in-services were completed a knowledge check was completed for retention. During an interview on 8.29.25 at 2:00 PM CNA M stated there were 4 in-services that he had to complete before he was allowed to start his shift today. He stated that the overall point of all 4 in-services was communication, who to communicate to and what to look for. He stated when it came to abuse/neglect look for any new wounds or injuries on the resident and pay attention to if the resident was acting normal that day. He stated if anything seemed off with the resident you were to report it to the charge nurse. He stated if a resident was found on the floor from a fall, then he would call out for help from another CNA to get the charge nurse or he would have a CNA stay with the resident while he went to get a nurse to come do an assessment of the resident. He stated any abuse/neglect witnessed should be reported to the administrator immediately. During a phone interview on 8.29.25 at 2:00 PM CNA A stated that there were 4 in-services she had to complete before she was allowed to work last night. She stated that 3 were more to both types of staff while the 4th in-service was more for nursing staff. She stated abuse neglect, to make sure anytime she were to witness any type of abuse/neglect it was to be reported to her chain of command. She stated she would let her nurse/charge nurse know but knows the abuse coordinator was the administrator. She stated when it came to falls, anytime a resident was observed falling or found on the ground she was to report/call for help to have the nurse come and assess the resident. She stated she was not to touch or move the resident in any, way, but only to make sure to get help for the resident and for a nurse to come and assess the resident. She stated neuros were covered but that was more for nurses and not CNAs. she stated lastly, they covered documentation, again more towards nursing but also if anything abuse/neglect, injury, or fall were observed she would need to document everything and then use the chain of command to communicate everything that she observed. She stated at the end there was a question and answer and then a recall session of the in-services to test retention of education. During an interview on 8.29.25 at 2:00 PM CNA C stated that he was part of 4 in-services before he was allowed to work. He stated that one of the in-services was more associated to the nursing staff. He stated firs they discussed abuse/neglect and what to look for. He stated look out for any injuries to the resident or new cuts, bruising etc. he stated who to communicated to regarding any information with any injuries or abuse neglect to the charge nurse and the administrator. He stated that even if the injury were to look old or new or not that serious all injuries were to be communicated using the chain of command. He stated another in-service covered what to do as a CNA if you were to find a resident on the floor, weather it was witnessed or not and to not touch the resident but to get the nurse to do an assessment on the resident. He stated all information was good and needed to be heard even as a refresher. (continued on next page)

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	08/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of 4 in-services- Abuse/neglect-in-service provided by the facility. Signature pages for all staff provided. Signatures of all employees were observed on signature pages. In-service dated 8.28.25. presented by DON. Subjects covered, abuse, neglect, exploitation, who to report to, how to report and what constitutes as abuse or neglect. Which can include even new injuries. Report to charge nurse, don or administrator. Falls and head injuries in-service provided by the facility. Signature pages for all staff provided. Signatures of all employees were observed on signature pages. In-service dated 8.28.25. presented by DON. Subjects covered what constitutes as a fall, what constitutes as a head injury, who to report to, how to report and what to do if fall was witnessed or not witnessed. Documentation in-service provided by the facility. Signature pages for all staff provided. Signatures of all employees were observed on signature pages. In-service dated 8.28.25. presented by DON. Subjects covered documentation that must be completed such as an incident report the second an incident occurs. What documentation must be completed and started in the electronic system, such as neuro checks and communication to physician, family, chain of command/don and then administrator. Abuse/neglect-in-service provided by the facility. Signature pages for all staff provided. Signatures of all employees were observed on signature pages. In-service dated 8.28.25. presented by DON. Subjects covered what constitutes the injury to start neuro checks vs sending the resident directly to the hospital. Record review of RN B was educated and suspended pending investigation. During interview with DON, RN has been terminated from position at the facility. Signature sheet provided by facility with employee RN signature of report of employee education. Dated 8.28.25. Second Report of education dated 8.27.25 presented by COR to DON with DON signature provided subject covering neuro checks, policy, falls and head injury unwitnessed fall. Record review of 14 residents were reviewed for anticoagulant completed by DON on 8.28.25. Face sheets and dosages provided. &

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	08/29/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	08/29/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 7 (Resident #1) residents reviewed for quality of care in that: The facility staff failed to assess and monitor Resident #1, when Resident #1 was identified [DATE] as having a cut to the right side of his head, after an unwitnessed fall, which resulted in the resident being sent to the emergency room and diagnosed with a subdural hematoma (brain bleed) and death on [DATE]. An Immediate Jeopardy (IJ) situation was identified on 8.28.25. The IJ template was provided to the facility on 8.28.25 at 3:05 pm. While the IJ was removed on 8.29.25 the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of isolated, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures put residents at risk of not receiving treatment/care interventions when needed for changes in resident condition. The findings included: Record review of Resident #1 face sheet he was a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #1's diagnoses included encephalopathy (a condition in which the brain does not function properly), dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), depression and hypertension. Resident # 1's BIMS score was 5, indicating severe cognitive impairment. Record review of Resident #1 pharmacy orders indicated Eliquis 5mg (blood thinner used to reduce risk of stroke and blood clots): Give 1 tablet by mouth two times a day related to unspecified atrial fibrillation. Record review of Resident #1's care plan dated 8.22.25 indicated: The resident is high risk for falls. Res has spontaneous behaviors and attempts to self-transfer. The resident will be free of falls through the review date. The resident will not sustain serious injury through the review date. 6/19- actual fall, nonskid footwear. 7/5- actual fall, frequent reminders to use call light. 8/13- actual fall, visual reminder in the bathroom. 8/15- actual fall, visual reminder in room. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Encourage resident to ask for assistance with all transfers. Bleeding was also notated in care plan, linked below. Eliquis was not directly named in care plan. Risk for Bleeding Date Initiated: [DATE], Resident Will Be Free of Falls Date Initiated: [DATE], Target Date: [DATE], Resident Will Show No Signs/Symptoms of Bleeding Date Initiated: [DATE] Target Date: [DATE], Avoid unnecessary invasive procedures, punctures or injections Date Initiated: [DATE], Evaluate blood pressure, Date Initiated: [DATE], Evaluate fall risk on admission and PRN Date Initiated: [DATE], Evaluate for blood in stools, Date Initiated: [DATE], Evaluate for change in level of consciousness, Date Initiated: [DATE], Evaluate for hematemesisDate Initiated: [DATE], Evaluate for hematuria, Date Initiated: [DATE], Evaluate heart rate, Date Initiated: [DATE], Evaluate skin for evidence of impaired coagulation (bruising, petechia, bleeding from orifice), Date Initiated: [DATE], If fall occurs, alert provider, Date Initiated: [DATE]. During interview on 8.27.25 at 10:15 AM physician A (Hospital ER MD) stated that based on the injury and the combination of Resident #1 being [AGE] years old and on 5mg of Eliquis, along with a cut to the right side of the head reported by family as occurring on Monday [DATE] started the bleed. She stated when she saw the resident in the ER on Wednesday [DATE], he had a small scratch/cut on the top right side of the head. She stated due to Resident #1 being on a blood thinner, and the fact that there was a head injury even anything as minor as a scratch/cut can be an indication of a brain bleed. The resident should have had continued monitoring, even if there was 1 good neurological check, would not mean there was no brain bleed. Often times with a blood thinner of any type, there would be a bleed that would not be immediately noticed, and a resident could be talking with you fine at times, then symptoms could be increased tiredness and lethargy. She stated by the time Resident #1 was seen in the ER on [DATE] the bleed was too significant and could not be fixed. She stated this was the resulting factor that caused Resident #1 to pass away on [DATE]. During an interview on 8.22.25 at 10:05 AM Resident #1's family member stated that on [DATE] she was at the facility and Resident #1 had a fall in his shower. She stated Resident #1 sustained a cut to his right elbow and the top right side of his head. She said he had passed away the morning of [DATE]. She stated that she heard a CNA C tell Resident #1 not to get up off of the toilet, she was going to go grab a towel or something. She stated next thing she knew Resident #1 was found on the floor of the shower. She stated a CNA C came to the room that day to get Resident #1 up and into the restroom. She stated she heard CNA C tell Resident #1 do not get up or move from the toilet she