

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, for 1 of 1 kitchen as evidence by: The facility failed to ensure:The low-temperature dishwasher failed to reach the required hot water minimum temperature of 120 degrees in the kitchen.This failure placed the residents at risk for foodborne illness from dishes not being sterilized properly. The findings included:In an observation of the initial tour of the kitchen on 04/07/2026 at 9:25 a.m., the low-temperature dishwasher was being utilized by [NAME] A. The hot water temperature was observed at 100 degrees on the bottom thermometer attached to the dishwasher. The top thermometer was observed at 90 degrees. In an interview with [NAME] A, she said the hot water temperature only gets to 100 degrees since they put in the new hot water heater. There are 2 thermometers on the machine, and she looks at the bottom one when recording the temperature for the day. A record review of the facility dishwasher testing log on 04/08/2026, revealed the following temperatures for:April 2026 for morning, noon and night:1st - 100 degrees, 90 degrees, 100 degrees2nd -100 degrees, 90 degrees, 100 degrees3rd - 100 degrees, 100 degrees, 110 degrees4th - 90 degrees, 100 degrees, 100 degrees5th - 100 degrees, 90 degrees, 95 degrees6th - 110 degrees, 100 degrees, 110 degrees7th - 90 degrees, 98 degrees, 90 degrees8th - 98 degrees, 98 degrees, 98 degrees.In an interview with the Dietary Manager on 04/07/2026 at 2:55 p.m., she said the hot water temperature had been below 120 degrees since they got the new hot water heater. She said that she had not told anyone about it. She said a potential negative outcome would be food borne illnesses. She said she had not received any reports of food borne issues. In an interview with the Maintenance Director on 04/08/2026 at 10:30 a.m., he said no one had said anything to him about the hot water temperature of the dishwashing machine not being hot enough. He said they recently got a new hot water heater, and the temperature had been set to 130 degrees. In an interview and record review of the infection control log with the DON - Infection Control Specialist on 04/09/26 at 9:43 a.m., she said there had not been any outbreaks of food borne illnesses in the facility. Review of the infection control log revealed no foodborne illnesses. In an interview and observation on 04/09/26 at 9:46 am, [NAME] A said the water was a lot hotter than it was. An observation of the temperature of the dish machine was 140 degrees when it was tested at that time. In an interview with the Administrator on 04/09/26 at 9:55 a.m., he said the dishwashing machine was now testing at 140 degrees.Record review of the facility policy Sanitization, dated as revised November 2022, revealed the following [in part]: Policy Statement: The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation:5b. Low-Temperature Dishwasher (Chemical Sanitization):(1) Wash temperature (120 degrees).</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 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** Based on interview and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 3 of 5 residents (Resident #1, Resident #58 and Resident # 97) reviewed for comprehensive care plans.he facility failed to ensure the comprehensive care plan addressed:- Resident #1's wound on the right side of his neck. -Resident #58's plan for discharge. -Resident #97's care and maintenance of his double lumen PICC line (a line used to administer medications through a vein). These deficient practices could result in residents not receiving needed care to maintain optimum health and placing them at risk for infection and/or deterioration in their condition. Findings include:Resident #1 Record review of Resident #1's electronic face sheet dated 04.08.2026 revealed an [AGE] year-old male admitted on 05.19.2025 with diagnoses that include other fracture of upper and lower end of right fibula (bone in lower leg), shortness of breath, morbid obesity, and hypertension (high blood pressure). Review of Resident #1's quarterly MDS dated 01.28.2026 revealed Section C Cognitive Patterns BIMS score of 15 (cognitively intact). Record review of Resident #1's Care plan dated 01.28.2026 revealed no evidence of wound care for Resident #1's wound to the right side of his neck. Review of Resident #1's physician orders dated 04.08.2026 revealed: wound care treatment to right side of the neck: clean with normal saline/wound cleanser, pat dry with gauze, apply xeroform gauze, self-adhesive dressing. Every day shift for cyst to right side of neck. Lidocaine external gel 4%: apply to right neck topically every day shift for daily dressing changes. During an observation on 04.07.2026 at 10:00 a.m., Resident #1 was lying in bed with his eyes closed. Resident #1 had a dressing to the right side of neck dated 04.07.2026. Resident #58 Review of Resident #58's electronic face sheet dated 04.08.2026 revealed an [AGE] year-old female admitted on 03.10.2026 with diagnoses of Type 2 diabetes mellitus (chronic metabolic condition leading to high blood sugars), bipolar disorder (mental health condition), hypertension (high blood pressure), and chronic pain. Review of Resident #58's admission MDS dated 03.13.2026 revealed Section C-Cognitive Patterns BIMS score of 12 (cognitively intact), Section Q indicated Participation in assessment and goal setting-resident's overall goal remain in the facility. Record review of Resident #58's care plan dated 03.24.2026 revealed no evidence of a discharge plan. Review of Resident #58's physician orders dated 04.01.2026 revealed a regular diet, mechanical soft texture, regular consistency, quetiapine, trazadone, duloxetine, antiplatelet monitoring, Code status: Full Code. Resident #97 Review of Resident #97's electronic face dated 04.01.2026 sheet revealed a [AGE] year-old male admitted 03.17.2026 with diagnosis included Infection and inflammatory reaction due to unspecified internal joint prosthesis, Anxiety, Atrial Fibrillation (heart disease), Dementia (decline in memory). Review of Resident #97's admission MDS dated 03.17.2026 revealed Section C Cognitive status BIMS score of 3 (severely impaired), Section N Medications-antibiotic-yes. Section O Special treatments, procedures and programs- IV medications-yes, IV access-yes. Review of Resident #97's care plan dated 03.17.2026 revealed no evidence of goals or interventions for the use and maintenance of Resident #97's PICC line and no evidence of goals or interventions for PICC dressing change. Review of Resident #97's physician orders dated 04.01.2026 included: EBP (enhanced [NAME] precautions) Tyzavan (antibiotic) intravenous solution 200 mL intravenously every 18 hours for MRSA (methicillin-resistant staphylococcus aureus-bacteria) until 04.08.2026. There were no physician orders for maintenance of PICC line or dressing changes for PICC line. During an observation on 04.07.2026 at 10:30 a.m., Resident #97 was lying in bed with IV antibiotic infusing via gravity to double lumen PICC line located in right upper arm. The dressing was clean, dry, and intact and the skin surrounding the dressing was intact and no redness. During an interview with LVN A on 04.09.2026 at 11:19 a.m., she stated she had provided IV medications for Resident #97,she stated he (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>had a double lumen PICC to RUA. She was unable to locate a physician order for PICC line flushes or dressing changes. She stated there should be an order, she said it was not on the TAR for PICC dressing changes or on the MAR for flushes of PICC line it could get missed. She stated not flushing the PICC line after each IV ABX dose could cause the PICC line to become blocked or not patent. She stated this could delay treatment for the resident. During an interview on 04.09.2026 at 11:25 a.m., RN B stated she changed the PICC line dressing for Resident #97 every 7 days. She stated she documented this in the progress notes. She stated there should be an order for PICC line dressing changes and for PICC line flushes for maintenance. She stated not having these orders could result in the task not being done. She stated PICC line dressing changes are done to prevent infection at insertion site of PICC and that flushes helped maintain the patency of the PICC line. She stated the resident came from another facility with the PICC line in place. She stated not maintaining patency of PICC line could delay treatment for the resident. There was no documentation in nurses progress notes for this dressing change. During an interview on 04.09.2026 at 12:25 p.m., the DON stated there should be physician orders for a PICC line for general maintenance. She stated there should be a physician order for saline flushes and dressing changes for the PICC line. She stated the negative outcome could be the PICC line not being patent, the dressing becoming soiled or loose and cause the resident to get a secondary infection. She stated wound care, wounds, discharge plans, and PICC lines should be care planned. She stated she was responsible for monitoring physician orders for accuracy. She stated she did not know how this failure occurred. She stated by it not being care planned the care for the PICC line could be missed. She stated LVN C was responsible for the care plans and that she (DON) was responsible for monitoring accuracy of the care plans. She stated the care plan addressed the PICC line being used for antibiotic therapy and felt that was sufficient. She stated she did not know that wound care for resident had not been care planned or the discharge plans for a resident. During a telephone interview on 04.09.2026 at 12:37 p.m., LVN C stated she had care planned the use of the PICC line. She stated she did not know that wound care for resident had not been care planned or the discharge plans for a resident. Review of facility's policy titled Care Plans Revision date March 2022 revealed: Policy statement A care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy interpretation and implementation The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The person-centered care plan: a. includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident and hazards as was possible and each resident receive adequate supervision and assistance devices to prevent accidents for 1 of 14 resident rooms reviewed for accident and hazards. The facility failed to ensure: The cover of an air conditioning unit was off on the ground in a 1 of 1 resident's room exposing the insides to the machine. The findings included: Observation of resident room [ROOM NUMBER] on 04/07/26 at 10:18 a.m., revealed in the secured unit, the cover of the air conditioning unit was off the unit and sitting on the floor. The insides to the air conditioner unit were exposed to the resident that occupied the room. In an observation and interview with LVN B on 04/09/2026 at 9:30 a.m., she said they had spring cleaning a few weeks ago and must not have been put back on correctly. A potential negative outcome for a resident is they could get shocked if they stuck their hand in the unit. LVN B put the cover back on the air conditioning unit. In an interview with the Maintenance Director on 04/09/2026 at 9:36 a.m., he said they had a spring cleaning on 3/18/26 facility wide, including washing the air conditioning units. It must not have been put back on correctly. In an interview with the DON on 04/09/2026 at 9:43 a.m., she said the facility had a spring cleaning a few weeks ago and cleaned all of the air conditioners. She said she was not aware of any covers being off the air conditioners. She said a potential negative outcome would be that a resident could stick their hand in it. In an interview with the Administrator on 04/09/2026 at 9:55 a.m., he said he was not aware of any covers being off the air conditioners. He said a potential negative outcome would be rodents would be able to get in the facility and a resident could stick their hand in it. A policy was requested but not provided by time of exit.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review the facility failed to ensure parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 residents (Resident #97) reviewed for IV therapy. The facility failed to obtain physician orders for the use and maintenance of Resident #97's PICC line. This deficient practice could result in residents not receiving needed care to maintain optimum health and placing them at risk for infection and/or deterioration in their condition. Findings include: Review of Resident #97's electronic face sheet dated 04.08.26 revealed [AGE] year-old male admitted 03.17.2026 with diagnoses including Infection and inflammatory reaction due to unspecified internal joint prosthesis, Anxiety, Atrial Fibrillation (heart disease), and Dementia (decline in memory). Record review of Resident #97's admission MDS dated 03.17.2026 revealed Section C Cognitive status BIMS score of 3 (severely impaired), Section N Medications-antibiotic-yes. Section O Special treatments, procedures and programs- IV medications-yes, IV access-yes. Record review of Resident #97's care plan dated 03.17.2026 revealed no goals or interventions for use and maintenance of PICC line. No goals or interventions for PICC dressing change. Record review of Resident #97's physician orders dated 04.01.2026 included: EBP (enhanced [NAME] precautions) Tyzavan (antibiotic) intravenous solution 200 mL intravenously every 18 hours for MRSA (methicillin-resistant staphylococcus aureus-bacteria) until 04.08.2026. There were no physician orders for maintenance of PICC line or dressing changes for PICC line. During an observation on 04.07.2026 at 10:30 a.m., Resident #97 was lying in bed with IV antibiotic infusing via gravity to a double lumen PICC line located in the right upper arm. The dressing was clean, dry, and intact and the skin surrounding the dressing was intact and no redness. During an interview with LVN A on 04.09.2026 at 11:19 a.m., she stated she had provided IV medications for Resident #97, he had a double lumen PICC to RUA. She stated she flushed the PICC line before and after use with 10 mL normal saline, she was unable to locate a physician order for PICC line flushes or dressing changes. She stated there should be an order and because it was not on the TAR for PICC dressing changes or on the MAR for flushes of PICC line it could get missed. She stated not flushing the PICC line after each IV ABX dose could cause the PICC line to become blocked or not patent. She stated this could delay treatment for the residents. During an interview on 04.09.2026 at 11:25 a.m., RN B stated she changed the PICC line dressing for Resident #97 every 7 days, she stated she documented this in the progress notes. She stated there should be an order for PICC line dressing changes and for PICC line flushes for maintenance. She stated not having these orders could result in the task not being done. She stated PICC line dressing changes are made to prevent infection at insertion site of PICC and that flushes helped maintain the patency of the PICC line. She stated the resident came from another facility with the PICC line in place. She stated not maintaining patency of PICC line could delay treatment for the resident. During an interview 04.09.2026 at 12:25 p.m., the DON stated there should be physician orders for a PICC line for general maintenance of the PICC line. She stated there should be a physician order for saline flushes and dressing changes for the PICC line. She stated the negative outcome could be the PICC line not being patent, the dressing becoming soiled or loose and cause the resident to get a secondary infection. She stated she was responsible for monitoring physician orders for accuracy. She stated she did not know how this failure occurred. She stated by it not being care planned the care for the PICC line could be missed. During a telephone interview on 04.09.2026 at 12:37 p.m., LVN C stated she had care planned the use of the PICC line for antibiotic therapy. She stated she did not know that wound care for resident had not been care planned or the discharge plans for a resident. Record review of facility's policy titled: Medication Administration-Intravenous Therapy dated 11.01.2025 revealed: Policy Statement Licensed nursing staff shall administer IV medications only through an appropriate vascular access device using (continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>aseptic technique, verified medication compatibility, and approved procedures. Definitions.PICC lineMay be used for central-approved medicationsVerify tip placement documentation prior to first useFollow central-line infection prevention practices. Procedure Verify order, medication, and IV accessAssess IV site and patencyScrub hub and administer medication per orderFlush line per protocolReassess resident and IV site. DocumentationMedication name, dose, route, rateIV access typeSite assessment-condition before and after administrationResident response</p>		