

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Five Points Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 Point West Parkway Amarillo, TX 79124	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26515</p> <p>Based on interviews and record review, the facility failed to ensure residents were free from abuse for 1 of 8 residents (Resident #2) reviewed for abuse.</p> <p>The facility failed to ensure Resident #2 was free from verbal abuse when on 1/23/25, the ABOM yelled at Resident #2 to get the fuck out of my office. Resident #2, who has Alzheimer's disease, was in front of the ABOM's desk and stroking his penis while asking her if she wanted to fuck.</p> <p>This failure could place residents at risk of mental anguish or emotional distress.</p> <p>This was determined to be PNC as the facility had implemented corrective actions prior to entry.</p> <p>Findings included:</p> <p>Record review on Resident #2's clinical record indicated Resident #2 was an [AGE] year-old male, initially admitted on [DATE], with the following diagnoses: Diverticulitis of large intestine with perforation an abscess (an inflammation or infection in one or more small pouches in the digestive tract which caused contents to leak in the abdomen which formed an abscess), muscle wasting and atrophy (causes muscles to lose mass and strength), difficulty in walking, psychotic disorder with delusions (cause abnormal thinking and perception and cannot tell what's real from what's imagined), major depressive disorder (persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), Alzheimer's disease with late on set (cognitive decline that typically develops after the age of 65), diabetes (too much sugar in the blood), protein-calorie malnutrition (reduced availability of nutrients leads to changes in body composition and function), hypokalemia (low level of potassium in the blood which can result in fatigue, muscle cramps, and abnormal heart rhythms), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), hypertension (high blood pressure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), heart failure (the heart doesn't pump blood as well as it should), rheumatoid arthritis (chronic inflammatory disorder usually affecting small joints in the hands and feet), benign prostatic hyperplasia without lower urinary tract obstruction (prostate gland enlargement that can cause urination difficulty), spinal stenosis (spaces inside the bones of the spine get too small), repeated falls and a fracture of lateral malleolus of right fibula (a break in the bone of outer side of the right ankle joint).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's quarterly MDS resident assessment, dated 12/30/24, documented the resident scored 11 of 15 on a mini-mental exam for cognitive awareness, Acute change in mental status, inattention, disorganized thinking.</p> <p>Record review of Resident #2's quarterly MDS resident assessment, dated 2/21/25, documented the resident score 9 of 15 on a mini-mental exam for cognitive awareness, he was moderately impaired for daily decision making.</p> <p>Record review of the Provider Investigation Report, dated 1/28/25, documented the following. On 1/23/25 at 4:40 p.m., the ABOM said, in front of two witnesses, stated she was cornered in her office by Resident #2. The ABOM stated Resident #2 said to her, will you fuck me while he was stroking his penis. The ABOM yelled at Resident #2 to get the fuck out of her office three times. ABOM was suspended on 1/24/25 when she arrived for work. Resident #2 was referred to a behavior hospital for alleged sexually inappropriate behaviors. Quality of Life rounds on residents and in-serviced staff members on abuse/neglect, dementia behaviors. (The two witnesses to this conversation were the DON and SW) Review of the Provider Investigation Report included documentation of the inservices provided to staff to cover Abuse/Neglect, dementia training with 56 staff attending. In addition, quality of life rounds were conducted with resident after the incident to ensure all residents did not have any additional concerns.</p> <p>Record review on 2/20/24 of the nurses' notes for Resident #2 revealed the following:</p> <p>1/23/25 at 5:03 p.m. - called doctor's office on inappropriate behaviors at this time. New order for Paxil 50 mg. Stop Cymbalta and Zoloft once Paxil is in.</p> <p>(Paxil - treats depression, anxiety disorders, obsessive-compulsive disorder, and posttraumatic stress disorder)</p> <p>(Cymbalta - treats depression, anxiety, diabetic peripheral neuropathy, fibromyalgia and chronic muscle or bone pain)</p> <p>(Zoloft - treats depression, obsessive-compulsive disorder, posttraumatic stress disorder, social anxiety disorder and panic disorder)</p> <p>1/24/25 at 8:50 a.m. - location of event: ABOM office</p> <p>Condition/behavior at time of event: Cognitive impairment, wanders, requires cueing.</p> <p>No pain or injury</p> <p>Was told by the ABOM that Resident #2 cornered her in her office and asked her if she wanted to fuck while stroking his penis three times.</p> <p>Initial treatment/new orders: skin assessment done on resident.</p> <p>Resident Statement: resident had no recollection of event and stated, I think my care is wrecked.</p> <p>Physician and family member notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/24/25 at 11:35 a.m. - Resident was sent to a behavioral hospital for psychiatric evaluation.</p> <p>Record review of the Inservice Training Reports reflected the facility conducted the following in-services on:</p> <p>1/25/25 - Abuse/Neglect/Dementia Training</p> <ol style="list-style-type: none"> Any abuse or neglect noted needs to be reported to the Administrator, take immediate action to stop abuse and report to the Administrator. Please see attached policy and procedure for Abuse/Neglect When a resident with dementia approaches you inappropriately, ensure you remain calm and try to redirect resident. If resident tries to become aggressive or you cannot redirect, please try, and get away from the situation, and remember to always communicate these instances with a manager so situations can be followed up. <p>1/26/25 - Abuse/Neglect/Dementia Training</p> <ol style="list-style-type: none"> Any abuse or neglect noted needs to be reported to the Administrator, take immediate action to stop abuse and report to Administrator. Please see attached policy and procedures for abuse/neglect. Workplace burnout is a state of mental, physical, and emotional exhaustion that occurs when chronic workplace stress goes unmanaged. Ensure we are notifying managers if you are feeling burnt out at work. If you see a staff member being short with you or not acting like themselves, this could be a sign of burnout and either charge nurse or manager needs to be notified in order to address the situation. Signs of Burnout: Symptoms: Feeling tired, exhausted, or powerless Having trouble sleeping Experiencing headaches, muscle pain or stomach issues Feeling disconnected from work or uninterested in it Turning to substances like alcohol or drugs to cope Feeling helpless, hopeless, or resentful <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/29/25 at 6:50 p.m., LVN B stated Resident #2 was confused and tends to wander in other rooms looking for his wife who had passed away several years ago. LVN B stated he had heard about the incident with the ABOM, but he had never witnessed him doing any kind of sexual behaviors before.</p> <p>During an interview on 2/20/25 at 8:25 a.m., the DON stated about 5:00 p.m. at the end of the day shift on 1/23/25, the ABOM came to the nurses' station and said Resident #2 was sexually inappropriate with her. The DON immediately placed Resident #2 one on one after the DON was made aware of the situation and the ABOM quickly left the facility. The DON stated he called the physician and he changed some of Resident #2's medications. The DON stated the next morning, the DON met with the ABOM and LVN A in his office. The DON stated The ABOM was suspended until the investigation was completed then she was terminated for verbally abusing a resident. The DON stated the ABOM admitted she yelled at Resident #2 to get the fuck out of my office three times. The DON stated Resident #2 was sent to a behavior hospital and was now on Hospice. The DON stated Resident #2 labs were out of [NAME], his medications were changed, the family decided to place him on Hospice, Resident #2 was currently back in the facility and had no further inappropriate behaviors.</p> <p>During an interview on 2/20/25 at 1:35 p.m., the ABOM stated she was in her office sitting at her desk with her back against the wall. The ABOM heard a noise and when she turned around, Resident #2 was six inches away from her. The ABOM stated she stood up immediately and hoped since she stood up, she was hoping Resident #2 would move back but he did not. The ABOM stated Resident #2 asked her several times, Are you going to fuck me or not and he started to roll forward towards her. The ABOM stated that she yelled very loudly for Resident #2 to get the fuck out of her office, but no one came. The ABOM stated she was up against the wall in her office. The ABOM stated she told Resident #2 to get the fuck out of her office. The ABOM stated she was loud and direct and hoping someone would come to her rescue. The ABOM stated Resident #2 blocked the doorway and said, Is this the place to fuck? The ABOM stated she ran to the nurses' station and the ADON was there and she told the ADON to get Resident #2 out of her office because he was still stroking himself. The ABOM stated they got Resident #2 out of her office, and she left the facility and did not say a word to anyone. The ABOM came back to the facility in the morning and Resident #2 came back to her office and she told him to get away from her office. The ABOM stated the Regional Director of Nurses suspended her and then she was terminated.</p> <p>Record review on 2/20/25 of a statement handwritten by SW, dated 1/28/25, documented the following:</p> <p>In regard to Resident #2 - ABOM was moved to my office so they shared an office. Resident #2 would wander around the halls and the ABOM had commented when Resident #2 passes by that he (Resident #2) gave her the ick vibes. I informed her that the situation was pure confusion and innocent, and she shrugged her shoulders. The day after her incident with Resident #2 (1/24/25), Resident #2 passed by the office around 8:20 a.m., and she yelled out, You need to get the fuck away from this office. Resident #2 kept rolling past and did not even glance in the direction of the office.</p> <p>Record review of the facility's policy on Abuse/Neglect, revised 3/29/18, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: Threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc.</p> <p>A. Screening: The facility will conduct criminal background checks of all personnel.</p> <p>B. Training: The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly.</p> <p>C. Prevention: The facility will provide the residents, families, and staff an environment free from abuse and neglect.</p> <p>D. Identification: The facility will identify and investigate events that may constitute abuse/neglect.</p> <p>E. Reporting: Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services.</p> <p>F. Investigation: All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated.</p> <p>G. Protection: The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property investigation.</p> <p>Interviews conducted throughout this two day investigation revealed all staff had knowledge and understanding of the in-services they received covering abuse/neglect and dementia training and signs of staff burnout.</p>		