STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676455	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points Nursing and Rehabilitation	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in accordance with professional standards and practices, maintain medical records on each resident that are accurately documented for 1 (Resident #1) of 7 residents reviewed for accuracy of medical records. The facility failed to ensure LVN A documented the correct time Resident #1 and his family were provided with copies of his baseline care plan. The facility failed to ensure LVN A documented the correct time Resident #1's family and doctor were notified of his fall on 05/21/25. The facility failed to ensure RN B documented the times correctly on 3 progress notes in Resident #1's chart on 05/23/25. These failures could place residents at risk of not receiving necessary care/treatment due to inaccurate medical records. Findings Included: Record review of Resident #1's admission record dated 06/04/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia (paralysis) affecting right dominant side, cerebral infarction (stroke), difficulty in walking, and unsteadiness on feet. Resident #1 discharged from the facility on 05/23/25. The time listed for discharge was 04:30 PM. Record review of Resident #1's care plan revealed it was a baseline care plan initiated on 05/21/25. Resident #1 was noted to be at risk of falling. Record review of Resident #1's EHR in the MDS tab revealed no comprehensive MDS was completed due to the short duration of his stay in the facility. Record review of Resident #1's transfer form completed by DON on 05/23/25 revealed Resident #1's transfer to the hospital for altered mental state was effective on 05/23/25 at 03:10 PM. Record review of Resident #1's progress notes from 05/21/25 to 05/23/25 revealed the following: (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note on 05/21/25 at 03:02 PM by LVN A which indicated Resident #1 was admitted to the facility on [DATE] at 03:02 PM. A note on 05/21/25 at 04:00 PM by LVN A which indicated a copy of Resident #1's baseline care plan was provided to Resident #1 and to his family member on 05/21/25 at 12:00 AM. A note on 05/21/25 at 05:29 PM by LVN A which indicated Resident #1 had a fall. The note further indicated Resident #1's doctor and family were notified of his fall on 05/21/25 at 12:00 AM. A note on 05/23/25 at 03:10 PM by DON which indicated Resident #1 was transferred to the hospital. A note on 05/23/25 at 04:47 PM by RN B which indicated a neuro assessment was completed on Resident #1. A note on 05/23/25 at 04:48 PM by RN B which indicated vital signs taken of Resident #1. A note on 05/23/25 at 04:51 PM by RN B which was a fall follow-up and indicated Resident #1 had continuous pain on his right side. During an interview on 06/04/25 at 11:21 AM DON was asked for actual family and physician notification times for Resident #1's fall on 05/21/25. He looked in the EHR and stated he would ask LVN A. During an interview on 06/04/25 at 11:26 AM DON stated LVN A notified Resident #1's family and physician at the time of the note in his EHR (05:29 PM) on 05/21/25. During an interview on 06/04/25 at 11:51 AM DON stated Resident #1 discharged from the facility on 05/23/25 at 03:00 PM. He stated Resident #1 did not return to the facility after that discharge. DON looked at progress notes in Resident #1's EHR and stated, I have no idea why RN B had documented assessments of Resident #1 at times later than the time of his discharge from the facility. During an interview on 06/04/25 at 11:57 AM RN B stated she noticed her notes had not been completed on Resident #1 and she completed the notes with information she had gathered prior to his discharge from the facility and did not change the time of her documentation. During an interview on 06/04/25 at 11:58 AM DON stated he was starting an in-service for nurses to address getting times right in documentation. During an interview on 06/04/25 at 12:12 PM RN B stated residents could be negatively impacted by inaccurate medical records. She stated she was not aware, prior to 06/04/25, of the expectation that assessments in the EHR be entered at the point of assessment. RN B stated it was possible to enter the assessment later and adjust the time of the assessment and that was what she should have done. During an interview on 06/04/25 at 02:45 PM LVN A stated residents might not receive needed care if their medical records are inaccurate. During an interview on 06/04/25 at 03:30 PM LVN C stated it was important to document times accurately in residents' medical records. She stated inaccurate medical records could negatively affect residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/25 at 03:40 PM LVN F stated residents could be negatively affected by inaccurate medical records. She said, If medical record is inaccurate, they (residents) wouldn't get proper care they (residents) need. During an interview on 06/04/25 at 03:47 PM ADON D stated a resident could be negatively impacted by inaccurate medical records, but it would depend on what is inaccurate. She stated the nurses in the facility were trained on documentation on the job and in nursing school. During an interview on 06/04/25 at 03:49 PM ADON E stated a resident could be negatively impacted by inaccurate medical records depending on what is inaccurate. Regarding training facility nurses on accurate documentation, she said, We do in-services, and we monitor documentation to make sure it is being done in a timely manner. During an interview on 06/04/25 at 03:55 PM DON stated it depends on what you're charting whether or not inaccurate medical records would negatively impact resident care. During an interview on 06/04/25 at 03:58 PM LVN A stated she did not accurately document the times Resident #1's family and physician were contacted on 05/21/25 regarding his fall because she did not realize they were inaccurate until she had signed the document. During an interview on 06/04/25 at 04:20 PM DON stated nurses were trained on documentation in nursing school and when something like this (inaccurate documentation in Resident #1's EHR by LVN A and RN B) happens. Record review of an undated facility policy titled Documentation revealed the following: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident . It has legal requirements regarding accuracy and completeness . 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 5. Each entry will be dated and timed.