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	01/08/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' environment remained free from accidents as was possible and each resident received adequate supervision and assistance devised to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accidents, hazards and supervision.The facility failed to ensure Resident #1 did not elope from the facility when Resident #1 left the facility in the middle of the night, without anyone knowledge, and ended up 0.4 miles from the facility trying to obtain a hotel room for the night.The noncompliance was identified as PNC. The IJ began on 12/10/25 when Resident #1 eloped from the facility. The facility had corrected the noncompliance before the investigator entered the facility.This failure could place residents at risk of serious injury or serious harm and placed residents at risk of heat or cold exposure, dehydration and /or other medical complications, of being struck by a motor vehicle.Findings included: Record review of Resident #1's Face Sheet, undated, documented a [AGE] year-old male was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (a brain dysfunction from a chemical imbalance due to an underlying illness, causing confusion, memory issues, personality changes, or coma), enterocolitis due to clostridium difficile (a serious bacterial infection causing diarrhea, abdominal pain, and fever, often triggered by antibiotic use disrupting gut flora), protein-calorie malnutrition (a serious condition from not getting enough protein and/or calories, leading to poor growth, weight loss, weakened immunity and increased infections), hypertension (high blood pressure), acute pulmonary edema (a life-threatening emergency where fluid rapidly fills the lungs air sacs, causing sever shortness of breath), acute kidney failure (kidneys rapidly stop filtering waste and balancing fluids which leads to toxic buildup in the blood), intestinal obstruction - unspecified as to partial or complete obstruction (blockage - partial or complete - in the small or large intestine, preventing food, liquid, gas and stool from passing through) and cognitive communication deficit (difficulty with communication due to impaired thinking or neurological conditions affecting memory, attention, problem-solving and social cues, making it hard to organize thoughts, follow conversations, or understand instructions). Record review of Resident #1's initial Care Plan, dated 12/5/25, revealed the following:The resident has an alteration in neurological status related to metabolic encephalopathy. Interventions: cueing, reorientation as needed, pain management as needed, PT, OT and St evaluate and treat as needed.The resident has impaired cognitive function/dementia or impaired thought processes. Interventions: administer medications as ordered, engage the resident in simple, structured activities that avoid overly demanding tasks, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status.The resident is at risk for falls. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: have residents' call light within reach and encourage residents to use. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing.Record review of Resident #1's Care Plan, updated on 12/10/25 after elopement, revealed the following:At risk for elopement as evidenced by: resident left the facility. Goal: will remain safe within facility unless accompanied by staff or other authorized person through review date. Interventions: resident placed one on one until family picked him up, assess/record/report to MD risk factors for potential elopement such as: wandering, repeated requests to leave facility, statements such as I'm leaving I'm going home, attempts to leave facility, elopement attempts from previous facility, home or hospital, supervise closely and make regular compliance rounds whenever resident is in room, if the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc.Record review of Resident #1's Medicare 5-day MDS resident assessment, dated 12/10/25, documented the resident scored 5 of 15 on a mini-mental exam for cognitive awareness and he was not capable of making informed decisions and he was independently ambulatory.Record review of Resident #1's nurses notes documented the following:12/10/25 at 2:08 a.m. - A local policeman called and asked if we had Resident #1 as a resident, I informed him that we did, they stated he was at a local hotel trying to get a room. The police brought Resident #1 back, spoke with Resident #1 and got him to his room. Resident #1 stated that he was being held hostage, I explained he was on contact isolation due to infection. Resident #1 stated he didn't want to be here. Called and spoke with Resident #1's family member and voiced understanding to what had happened and stated the family member would come and get him so he would not be confined, and it would please him. LVN spoke with the Administrator and explained what was going on, 400 door not shutting or locking.12/10/25 at 2:10 a.m. - Weekly Skin assessment: surgical incision present: yes, Location - 16 staples intact to center abdominal area, no redness, drainage or warmth noted.12/10/25 at 9:28 a.m. - Elopement Follow-up: currently: exit seeking, increase wandering, agitation, asking to leave or go elsewhere, 1 on 1 monitoring, patient to discharge by request.12/10/25 - Resident was interviewed at this time to determine resident can remain in facility, at this time, resident is one on one and wishes to go home with family member, Resident #1 states that he does not like being here because he must be isolated into his room. Family member is on their way from out of state and resident will discharge home with the family member. Currently, the resident is restless in room and remains one to one.12/10/25 at 10:38 a.m. - family member was here at this time to pick up resident, the family member understood that resident left facility last night and ended up in a hotel and was retuned by police. Family member was also given discharge instructions and medications. No further needs.12/10/25 at 12:44 p.m. - came in at 6:15 a.m. to sit with Resident, Resident was trying to leave the building. resident kept pacing from bed to bathroom to window, the resident kept wanting to leave. A family member picked resident up at 10:30 a.m. Record review of the Provider Investigation Report, dated 12/16/25, and filled out by the Administrator, reflected Resident #1 was last seen by staff at 12:20 a.m. during rounds. At approximately 1:10 a.m., the facility received a call from the local police department stating Resident #1 was at a local hotel approximately 0.4 miles away from the facility. It was 52 degrees outside, and Resident #1 was wearing a shirt, jeans, jacket and boots. Resident #1 stated he wanted to reserve a hotel room because he felt like a hostage at our facility because he was on contact isolation for C-diff. The local police department brought Resident #1 back to the facility, a skin assessment was conducted and there were no new injuries. Administrator arrived at facility and assessed all exit doors for function, initiated elopement in-service, interviewed staff, and verified Resident #1 was one on one. Resident noted to be asleep in his room. Staff posted at all exit doors until system cleaned by (continued on next page)

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