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Form Approved OMB
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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 03/09/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #1) of 6 residents reviewed for medication administration.The facility failed to ensure Resident #1's opioid pain medication was refilled timely.This failure could place residents at risk of increased pain and/or diminished quality of life.Findings Included:Record review of Resident #1's admission record dated 03/09/26 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 02/07/26. She had diagnoses that included, but were not limited to, chronic pain syndrome and angina pectoris unspecified (chest pain).Record review of Resident #1's annual MDS assessment completed on 01/19/26 revealed a BIMS of 15 which indicated intact cognition. Section J Health Conditions revealed Resident #1 had received scheduled pain medication during the look back period. She occasionally had pain that rarely affected her sleep or activities of daily living. Resident #1 rated her pain at 5 out of 10. Section N Medications revealed Resident #1 received opioid medication during the 7-day look back period.Record review of Resident #1's care plan initiated on 04/22/25 revealed the following: . The resident uses medications for Pain management. The resident has a potential for uncontrolled pain . Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.Record review of Resident #1's MAR dated November 2025 revealed 10 missed doses of oxycodone-acetaminophen oral tablet 5-325 MG. The MAR revealed she missed 3 doses on 11/01/25 at 12:00 PM, 04:00 PM, and 08:00 PM. The first 2 missed doses were labelled as unavailable. The last missed dose on this date was labelled as see nursing notes. Resident #1 missed the 08:00 AM, 12:00 PM, 04:00 PM, and 08:00 PM doses on 11/02/25. All four missed doses were labelled as see nursing notes. Resident #1 missed the 08:00 AM, 12:00 PM, and 04:00 PM doses on 11/03/25. All three missed doses were labelled as unavailable. The MAR revealed an order with start date of 11/01/25 for Acetaminophen-Codeine Oral Tablet 300-60 MG . Give 60 mg by mouth every 4 hours as needed for pain. Resident #1 took this medication once on 11/01/25, 4 times on 11/02/25, and twice on 11/03/25. The order ended for acetaminophen-codeine oral tablet 300-60 MG on 11/04/25.Record review of Resident #1's MAR dated January 2026 revealed 11 missed doses of oxycodone-acetaminophen oral tablet 5-325 MG. The MAR revealed she missed two doses on 01/03/26 at 04:00 PM and 08:00 PM. The 04:00 PM dose was labeled unavailable. The 08:00 PM dose was simply labelled as not given. The MAR revealed Resident #1 missed three doses on 01/04/26 at 08:00 AM, 12:00 PM, and 04:00 PM. All three missed doses were labelled as unavailable. The MAR revealed Resident #1 missed 4 doses on 01/05/26 at 08:00 AM, 12:00 PM, 04:00 PM, and 08:00 PM. The first three doses missed on 01/05/26 were labelled as unavailable. The last dose was labelled as see nursing notes. Resident #1 slept through her 12:00 PM dose on 01/24/26 and she was out of the facility for her 12:00 PM dose on 01/28/26. The MAR revealed an order with a start date of01/03/26 for traMADol HCl Oral Tablet 50 MG . Give 1 tablet by mouth four times a day for order is to be discontinued when oxycodone arrives. According to the MAR Resident #1 took this medication once (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 01/03/26, four times on 01/04/26, and four times on 01/05/26. The order was discontinued on 01/06/26.Record review of Resident #1's progress notes dated 10/06/25 to 11/06/25 revealed a note dated 11/01/25 for a new order for Acetaminophen-Codeine Oral Tablet 300-60 MG.Give 60 mg by mouth every 4 hours as needed for pain.Record review of Resident #1's progress notes dated 12/07/25 to 01/07/25 revealed a note dated 01/03/25 for a new order for traMADol HCl Oral Tablet 50 MG . Give 1 tablet by mouth four times a day for order is to be discontinued when oxycodone arrives.During an interview on 03/09/26 at 08:15 AM Resident #1's FM stated Resident #1 told her about missing several doses of her pain medication. FM stated, It happened more than once. She stated she did not notice Resident #1 experiencing pain during the time the medication lapsed. FM stated she did not know if the facility gave Resident #1 alternate pain medication as she waited for her oxycodone prescription to get refilled.During an interview on 03/09/26 at 08:26 AM Resident #1 she stated she remembered the facility not getting her pain medications refilled timely. She stated her pain medication lapsed twice, once in October 2025 and once in January 2026. Resident #1 stated the facility gave her an alternate pain medication in January to cover the time her oxycodone prescription lapsed. She stated, They (nurses) kept blaming the doctor and the doctor kept blaming the pharmacist. Everybody blaming everybody. I just know I wasn't getting it (her oxycodone pain medication)!During an interview on 03/09/26 at 09:47 PM MD stated the process to get oxycodone refilled was lengthy. He stated the facility had to turn in a request when there were 2 days of medication left and his staff had to do several specific tasks to ensure they were in line with DEA. He stated, Sometimes the pharmacy runs out of stock, and they don't let us know right away. MD stated there was no reason Resident #1's medication should have lapsed between refills.During a group interview on 03/09/26 at 10:11 AM ADON B stated she depended on her nursing staff to request medication refills when necessary. She stated the administering nurse should request a refill when there were 1-5 days of medication left. ADON A stated she did not think Resident #1 was negatively impacted by her pain medication lapsing because Resident #1 was on several other types of pain medication including a fentanyl patch. When asked, neither ADON had an answer as to why Resident #1's pain medication lapsed. ADON A stated it might have been because the nurses did not realize it was regularly scheduled for 4 times a day which meant 8 pills remaining only covered 2 days.During an interview on 03/09/26 at 10:17 AM DON stated he did not think Resident #1 was negatively impacted by her pain medication lapsing because the facility ordered different pain medication to cover the period of the lapse. He stated he was not sure why her medication lapsed in November 2025 and in January 2026. DON stated he suspected it was because the nurses administering her medication did not take into consideration that 4 pills covered only 1 day.During an interview on 03/09/26 at 11:29 AM RN C stated a resident with regularly scheduled opioid pain medication could be negatively impacted if the medication lapsed. She stated the resident could have increased pain or it could cause them to act out. RN C stated, We should call and get an order for something different until it is filled.During an interview on 03/09/26 at 11:36 AM LVN D stated if a resident's regularly scheduled opioid medication lapsed it could result in breakthrough pain for the resident.Record review of facility policy titled Medication Administration and General Guidelines and dated 2025 revealed the following: . Medications are administered as prescribed in accordance with.good nursing principles and practices.Record review of facility policy titled Controlled Medication - Ordering & Receipt and dated 2025 revealed the following: . 8. Schedule II controlled substance medications are reordered when a 3-5-day supply remains to allow for transmittal of required valid prescription to the pharmacist.