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	05/21/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure the resident had the right to and the facility made prompt efforts to resolve grievances the resident may have respond for 6 of 11 anonymous residents reviewed for resident rights. The facility failed to provide or demonstrate responses, actions, and rationale taken regarding resident concerns with laundry not being delivered, being delivered incorrectly, and missing items. This failure could place residents at risk of feeling unheard, experiencing feelings of anger and frustration, as well as a decreased quality of life. Findings included: In an interview at an undisclosed date at an undisclosed time 6 anonymous residents stated laundry was a big issue. The anonymous residents stated clothes went missing and were never replaced or clothes were delivered to the wrong rooms. The 6 anonymous residents stated they did not feel the issue was resolved. In an interview on 05/21/2026 at 9:02 AM, the LS indicated the issues usually happened because the facility could not keep a stable staff. The LS stated a negative outcome was that the residents could get upset. In an interview on 05/21/2026 at 9:36 AM, the AD stated a negative outcome with clothes not being returned was being upset if it was done in her home, it could turn into bigger problems, and the resident would not have clothes. In an interview on 05/21/2026 at 10:08 AM, the DON stated they in-serviced staff and went over all complaints. The DON stated they did not document any resolutions as it was resolved by usually finding the item. The DON stated a negative outcome would be the residents would feel like the grievance was invalid or we (facility) don't care. In an interview on 05/21/2026 at 10:13 AM, the ADM stated they resolved the concerns with in-services but didn't do a grievance. The ADM stated a negative outcome would be depending on the situation or depending on what it was. Record review of the Resident Advisory Council Minutes, dated 12/4/2025, under heading Old Business, 2nd sentence, Follow up on action on concerns from previous meeting minutes discussed with a Yes or No option, indicated neither Yes or No were marked. No documentation provided on responses, actions, and rational taken regarding resident concerns. Record review of the Resident Advisory Council Minutes, dated 01/08/2026, under heading Old Business, 2nd sentence, Follow up on action on concerns from previous meeting minutes discussed with a Yes or No option, indicated neither Yes or No were marked. No documentation provided on responses, actions, and rational taken regarding resident concerns. Record review of the Resident Advisory Council Minutes, dated 02/12/2026, Under heading Laundry and Housekeeping, stated clothing going missing/in other people's room. Putting roommate clothes mixed together. Under prompt Are there any concerns with laundry, items of clothing missing, it was answered with Yes. No documentation provided on responses, actions, and rational taken regarding resident concerns. Record review of the Resident Advisory Council Minutes, dated 03/12/2026, Under heading Laundry and Housekeeping, stated Clothes still missing Under prompt Are there any concerns with laundry, items of clothing missing, it was answered with Yes. No documentation provided on responses, actions, and rational taken regarding resident concerns. Record review of the Resident Advisory Council Minutes, dated 04/09/2026, Under heading Laundry and Housekeeping, stated Clothes missing Under prompt Are there any concerns with laundry, items of clothing missing, it was answered with Yes. No documentation provided on responses, actions, and rational taken regarding resident concerns Record (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident Rights, dated 11/28/2026, stated under heading Grievances- Line 2- The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. Record review of in-services of subject Response to Resident Council Concerns, dated 2/13/2026, stated the following: Line 15: Laundry should be returned to owner quickly and correctly. No additional in-services were provided on missing or incorrect delivered laundry. Record review of admission Packet -Company Policy and Required Notices, undated, stated under roman numeral V- Policy for Raising and Addressing Concerns, line 5- The administrator shall review the report and confirm that the appropriate action has been taken and ensure feedback is provided to the person making the complaint regarding the concern.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including the procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 4 of 4 medication carts reviewed for pharmacy services. The facility failed to ensure the Controlled Drugs Count Record on 4 medication carts for shift-to-shift narcotic counts did not have multiple blanks which indicated the narcotic count was not completed at shift change. This failure could result in narcotics being misappropriated from the facility which could result in ineffective treatment resulting in exacerbation of residents' disease process. Findings included: Observations on 5/19/26 of the facility's shift-to-shift narcotic count books revealed the following: *Controlled Drugs - Count Record for May 2026 documented the following on every sheet: Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication corresponds to the quantity stated on each controlled drug accountability record. At 2:30 PM - Hall 100 narcotic controlled drug count sheet for May had 11 blank spaces. At 2:45 PM - Hall 200 narcotic controlled drug count sheet for May had 2 blank spaces. At 3:12 PM - Hall 300 narcotic controlled drug count sheet for May had 1 blank space. At 3:18 PM - Hall 400 narcotic controlled drug count sheet for May had 3 blank spaces. During an interview on 5/21/26 at 2:20 p.m., the Adm. stated shift to shift narcotic counts were to ensure that the count was correct and accurate. The Adm. stated she was going to in-service nursing staff to ensure narcotic counts were to be completed at shift change. During an interview on 5/21/26 at 8:40 a.m., the DON stated the negative outcome would be that the nurse couldn't be held accountable if they did not sign in or out on the narcotic shift to shift sign sheet. The DON stated if there was no signature, the nurses couldn't be held responsible. The DON stated he was going to check the narcotic sign in sheets every day and hold the nurses accountable. During an interview on 5/21/26 at 8:50 a.m., RN A stated she signed the narcotic sheet every time she came on duty and if there was no signature, she dd not accept the cart. RN A stated if the nurse did not read the bottom of the sign in sheet, it tells you to sign the sheet when you accept the cart. RN A stated the nurse leaving the shift and the nurse coming on shift count the narcotics and sign the sheet which ensured the narcotic counts were correct. RN A stated if the narcotic count was incorrect, she would stop what she was doing and call the DON with the problem. During an interview on 5/21/26 at 9:00 a.m., RN B stated when the nurses did shift to shift change and signed the narcotic sheet, they were verifying the contents of the medication cart that all narcotics were accounted for. RN B stated the nurse coming on shift and the nurse coming off shift both signed the narcotic sheet, so the count was correct at that time. During an interview on 5/21/26 at 9:07 a.m., MA C stated she counted the narcotics with the nurse or MA coming off shift to verify all the narcotics were accounted for. MA C stated if the count was wrong and/or there were missing medications, she would stop what she was doing and call the DON to get further directions. During an interview on 5/21/26 at 9:13 a.m., the ADON/RN, stated nurses signed the narcotic sheet when taking responsibility for the cart which assured the narcotic count was correct. The ADON/RN stated the nurses did it again when coming off shift assuring the narcotic count was correct at the end of the shift. The ADON/RN stated staff knew to do it, she felt they had just gotten lazy. During an interview on 5/21/26 at 9:21 a.m., LVN D stated when she signed the narcotic count sheet, it was to ensure the narcotic count was correct. LVN D stated if there were no signatures or the count was incorrect, she would not accept the cart until the DON was contacted to provide the proper direction to proceed. Record review of the bottom section of the Controlled Drugs - Audit Record for the month, documents the following: Signing is acknowledgement the nurse has counted the controlled drugs and have found that the quantity of each medication corresponds to the quantity stated on each controlled drug accountability record. Any discrepancies must be noted in the comment column, indicated on each (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drug accountability record, and the DON notified. Record review of the facility's policy, Controlled Medications - Administration, revised 4/6/26, revealed the following: Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure:8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and was developed within 48 hours of a resident's admission for 1 of 18 residents (Resident #84) reviewed for baseline care plans. The facility failed to ensure Resident #84's baseline care plan reflected the resident's prescribed anticoagulant medication, Eliquis, including the need for monitoring related to anticoagulant use. This failure could result in staff not being aware of critical medication related risks and monitoring needs, placing residents at risk for delayed treatment and failure to provide necessary care and services. Findings included: Record review of Resident #84's face sheet, dated 05/19/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #84 had diagnoses which included acute respiratory failure with hypoxia (not enough oxygen in the blood), mild protein-calorie malnutrition and chronic combined systolic (congestive) and diastolic (congestive) heart failure, and atrial fibrillation (irregular heart rhythm) Record review of Resident #84's MDS face sheet revealed the admission MDS was not yet completed. Record review of Resident #84's baseline care plan, initiated on 05/15/2026, revealed no interventions, monitoring, or care plan focus related to anticoagulant therapy. No additional care plan addressing anticoagulant use had been developed. Record review of Resident #84's admission documentation, completed on 05/15/2026, revealed question 17 asked whether the resident was prescribed medications including anticoagulants; the anticoagulant medication was not selected. Record review of Resident #84's active medication order listing from the hospital, dated 05/14/2026, revealed Resident #84 was prescribed Eliquis 5 mg by mouth twice daily for atrial fibrillation. Record review of Resident #84's active physician orders as of 05/19/2026 revealed the following:Eliquis Oral tablet 5mg give 5 mg by mouth two times a day for anticoagulant (order date 05/15/2026) During an observation and interview on 05/19/2026 at 8:55 AM, Resident #84 was lying in her bed, she stated she was in the facility for skilled care and she took an anticoagulant medication. During an interview on 05/20/2026 at 2:59 PM, the DON stated when a resident was admitted to the facility an admission assessment was completed by the nurse on duty with the resident, The DON stated the assessment auto populated the base line care plan. The DON stated if information was missing during the admission the interdisciplinary team (IDT) would update that information within the 48-hour time frame. During an interview on 05/21/2026 at 9:04 AM, the ADM stated nurses were responsible for ensuring resident information, which included medications, were entered into the baseline care plan upon admission. The ADM stated the IDT, consisted of the DON, ADON, the MDS Coordinator and herself reviewed admission information the following day to finalize the baseline care plan and any information missed would be addressed at that time. During an interview on 05/21/2026 at 9:15, the ADON LVN stated the IDT, consisted of the ADM, DON, MDS Coordinator and herself were responsible to ensure baseline care plans reflected the residents' status, and medication needs. The ADON LVN stated the team would meet within 24 hours or next business day after a resident was admitted , to complete the baseline care plan. The ADON LVN stated if the baseline care plan was not completed correctly staff would not be aware of the residents' current status. During an interview on 05/21/2026 at 11:00 AM, RN A stated the nurse on duty was responsible for ensuring care was put in the baseline care plan upon a resident's admission and a possible negative outcome for not having a correct care plan would be staff would not be aware what a resident may need. During an interview on 05/21/2026 at 11:12 AM, the MDS LVN stated the IDT which consisted of the ADM, DON, ADON and himself were responsible for completing the baseline care plans within the 48-hour time frame., The MDS LVN stated anticoagulant therapy was important to include in the care plan so staff could monitor bruising, bleeding and abnormal laboratory (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	findings. Record review of a facility, undated, policy titled Baseline Care Plans revealed the following: This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standard of quality care. The baseline care plan will- Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders including physician orders.The facility will provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: A summary of the resident's medications.