STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745006	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points Nursing and Rehabilitation	1901 N. Hampton Rd. Desoto, TX 75115

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that focused on a resident's discharge goals, identified the resident's needs and how these needs would be met upon discharge, and ensure resident's comprehensive care plan to included the resident's individual discharge plan for five (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of five residents reviewed for discharge planning. The facility failed to develop a discharge plan for Resident #1 that focused on their specific needs and goals. The facility failed to develop a discharge plan for Resident #2 that focused on their specific needs and goals. The facility failed to develop a discharge plan for Resident #3 that focused on their specific needs and goals. The facility failed to develop a discharge plan for Resident #4 that focused on their specific needs and goals. The facility failed to develop a discharge plan for Resident #5 that focused on their specific needs and goals. This failure could affect residents' ability to discharge from the facility in a safe and orderly manner to ensure all discharge needs were identified and addressed. Findings included: Record review of Resident #1's Optional State Assessment MDS dated [DATE] revealed Resident #1 was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses of aphasia (disorder affecting the person's ability to communicate) and chronic obstructive pulmonary disease. BIMS score was not completed for this assessment. Record review of Resident #1's care plan with a revision date of 3/12/2024 revealed there was no discharge plan and no discharge interventions to meet the resident's needs and goals. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia, malnutrition, and lack of coordination. Resident #2's BIMS was listed as 09 (indicated moderate cognitive impairment). Record review of Resident #2's care plan with a revision date of 8/14/2024 revealed there was no discharge plan and no discharge interventions to meet the resident's needs and goals. Record review of Resident #3's Optional State Assessment MDS dated [DATE] revealed Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] and had a BIMS of 15 (suggested no cognitive impairment). Diagnoses were not selected on this assessment. Record review of Resident #3's care plan with a revision date of 3/12/2024 revealed there was no discharge plan and no discharge interventions to meet the resident's needs and goals. Record review of Resident #4's Quarterly MDS dated [DATE] revealed Resident #4 was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (disease that causes progressive memory loss) and hypertension (high blood pressure). Resident #4's BIMS was not completed for this assessment. Record review of Resident #4's care plan with a revision date of 8/27/2024 revealed there was no discharge plan and no discharge interventions to meet the resident's needs and goals. Record review of Resident #5's Quarterly MDS dated [DATE] revealed Resident #5 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of a cerebrovascular accident (stroke) and dementia. Resident #5's BIMS was listed as 07 (suggested severe cognitive impairment). Record review of Resident #5's care plan with a revision date of 7/29/2024 revealed there was no discharge plan and no discharge interventions to meet the resident's needs and goals. In an interview on 1/16/2025 at 9:42 a.m., the SW reported she did not complete a discharge care plan for every admission because most residents were long-term and were not planning to discharge. The SW reported not all residents had discharge care plans, and Resident #4 was discharged without a discharge care plan because the family would not agree on the discharge plan. The SW reported discharges were discussed in the morning meetings and that was how the team would know what the plan was for discharge. The SW stated she did not feel like there was a risk to the residents because they had a plan for discharge, but it was not on the care plan. In an interview on 1/16/2025 at 10:55 a.m., the DON stated discharge planning was done for skilled residents but not for long-term residents because they were not going to discharge anywhere. The DON reported discharge planning was done by the SW and was unsure if there was a discharge care plan. In an interview on 1/16/2025 at 4:50 p.m., the DON stated she was not aware of the protocol for this company concerning discharge planning and care plans because it was her second day. The DON stated the risk to the resident would vary based on the scenario, but they would work with everyone involved in the resident's care concerning discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/16/2025 at 11:12 a.m., the ADM stated discharge planning started when a resident arrived at the facility and there should be a discharge care plan. The ADM stated if the resident wanted to stay long-term then the care plan would state the resident's plan was to stay long-term. In an interview on 1/16/2025 at 5:06 p.m., the ADM stated the discharge plan should be included in the comprehensive care plan and the risks to the residents could be a delay in discharge. The ADM stated the social worker should have been including the discharge plan in the care plan, and she expected the SW to include the discharge plan in the care plan. Record review of the facility's policy titled Discharge Planning Process Policy, with a revision date of 11/28/2016, revealed Discharge Planning includes: . 4. Include regular re-evaluations of the resident to identify changes that require modification of the discharge plan and B) Developing an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to promptly notify the ordering physician of results which fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for one (Resident #2) of five residents reviewed for diagnostic services. The facility failed to promptly notify Resident #2's physician of her x-ray results for two days which revealed a left shoulder dislocation. This failure could place residents at risk for a delay in care, risk for pain and risk for suffering. Findings included: Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia, malnutrition, and lack of coordination. Resident #2's BIMS score was listed as 09 (indicated moderate cognitive impairment). Record review of Resident #2's care plan updated 10/18/2024 revealed Resident #2 had osteoarthritis which included interventions to report a decline in mobility, joint pain, or joint stiffness to the MD and had a history of falls with interventions updated after each fall. Record review of Resident #2's progress notes dated 10/04/2024 at 7:30 a.m., revealed Resident #2 was found on the floor in her bedroom, and Resident #2 stated she did not know how she fell . Resident #2 was assessed and pain medication was administered due to pain on the left side of the body. Pain level was not documented in progress notes. The notes also revealed hospice, the MD, and DON were notified. Record review of Resident #2's physician orders did not reveal an x-ray order for the fall on 10/04/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/16/2025 at 12:35 p.m., LVN A reported she found Resident #2 on the floor next to her bed on 10/04/2024. LVN A reported Resident #2 was partially on a fall mat on the floor when found and had a little pain with movement of the left arm. LVN A stated Resident #2 appeared comfortable after she was given pain medicine. LVN A stated she received an order from the MD to obtain an x-ray on Resident #2's shoulder and entered the order into the computer system. LVN A was unsure why the order was no longer showing in the system, but the x-ray was ordered on 10/04/2024. LVN A stated she worked the next night and checked for the x-ray results by logging into the computer. LVN A reported x-ray results would be available on the computer system and would be faxed. LVN A stated she checked the fax machine and computer system for x-ray results at the beginning of every shift and more often if she was waiting for results. LVN A reported she did not remember seeing Resident #2's x-ray results faxed, but she saw the results on the computer system on 10/06/2024 around 3:00 a.m . LVN A stated she sent a message to the hospice nurse when she saw the results and spoke with the hospice nurse the next morning. LVN A reported Resident #2 was declining prior to the fall and was on hospice. Record review of morphine (pain medication) record revealed directions to administer morphine every hour as needed for pain. The record also revealed morphine was administered as needed on 10/04/2024 at 8:00am, 11:00 a.m., 1:30 p.m., 7:11 p.m., and 9:43 p.m. On 10/05/2024 morphine was administered at 1:00 a.m., 2:00 a.m., and 4:00 a.m. On 10/06/2024 morphine was administered at 2:00 p.m. Record review of the x-ray report log provided by the x-ray company for 10/04/2024 revealed the order was called in by LVN A and the order was created on 10/04/2024 at 11:56 a.m. The report log revealed x-rays were taken 10/04/2024 at 6:47 p.m. and results were faxed to the facility on [DATE] at 10:21 p.m. The report log revealed the x-ray report was viewed in the computer system by the facility on 10/06/2024 at 12:55 a.m. In an interview on 1/16/2025 at 12:35 p.m., LVN A reported pain medication was administered after the fall on 10/04/2024 and Resident #2 was comfortable after receiving pain medication. Record review of Resident #2's progress notes dated 10/05/2024 at 4:34 a.m. revealed Resident #2 complained of pain and received pain medications as needed. Record review of Resident #2's progress notes dated 10/06/2024 at 2:53 a.m. revealed x-ray results were received and revealed Resident #2 had a dislocated left shoulder. This note also revealed Resident #2 was sleeping with no facial grimacing. The note did not state if anyone was notified of the x-ray results at that time. Record review of Resident #2's progress notes dated 10/06/2024 at 1:40 p.m., revealed the MD and DON were notified of the dislocated left shoulder. This note revealed Resident #2 denied pain at that time. Record review of Resident #2's progress notes dated 10/06/2024 at 5:22 p.m., revealed Resident #2 was transferred to the hospital. Record review of Resident #2's progress notes dated 10/06/2024 at 9:50 p.m., revealed Resident #2 returned from the hospital and her left shoulder was put back into place. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/16/2025 at 11:50 a.m., the MD stated he was notified of the x-ray results for Resident #2 on 10/06/2024. The MD reported it could cause a delay in treatment if results were not reported timely, and he expected results to be reported to him as soon as the facility received them. In an interview on 1/16/2025 at 3:51 p.m., ADON B reported x-ray results were faxed to the facility and were available on the computer. ADON B reported there was no requirement concerning how often to check the computer or fax machine. ADON B stated if results were not checked in a timely manner then the dislocation could get worse and the resident could have pain. In an interview on 1/16/2025 at 4:50 p.m., the DON reported she was not aware how x-rays were checked in this facility because it was her second day. The DON stated she expected the nurses to use due diligence and call her about any x-rays that were after a fall. The DON stated not obtaining results in a timely manner could place the resident at risk for pain. In an interview on 1/16/2025 at 5:06 p.m., the ADM stated she expected the ADON and Unit Manager to ensure labs and x-rays were checked. The ADM stated her expectation was that staff checked for x-ray results every shift. The ADM stated that obtaining results more than 24 hours after they were sent was not timely and could place the residents at risk for delayed care. The ADM stated she was unsure of the process at this facility because she had been there for one week. In an interview on 1/16/2025 at 6:19 p.m., the ADM reported the facility did not have a policy for diagnostic testing.