

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Five Points Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for four (Residents #1, #3, #4 and #8) of 10 reviewed for resident rights. The facility failed to ensure all residents #1, #3 #4 and #8's call lights were answered in a timely manner. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making are severely impaired. Her diagnoses include Dementia, Senile Degeneration of Brain, Stroke, Paralysis of her left side, and Protein-Calorie Malnutrition. The resident was dependent on staff for repositioning to her back, left, and right side. The resident did not have any skin conditions listed on admission. Record review of Resident #3's MDS dated [DATE] reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her cognitive skills for daily living decision making were intact. Her diagnoses included Type 2 Diabetes, Muscle wasting and Atrophy, Lack of Coordination, and Muscle weakness. Record Review of Resident #4's MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making are intact. Her diagnoses included Malnutrition, Difficulty walking, Lack of coordination, and kidney disease. Record review of Resident #8 MDS dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were moderately impaired. Resident #8 was diagnosed with Cerebral Infarction, Type 2 Diabetes, Vascular Dementia, End Stage Renal Disease. Record Review of Resident's Council Meeting Minutes dated 12/30/25 revealed complaints were made regarding call light response times. Record Review of Resident's Council Meeting Minutes dated 01/30/26 revealed complaints were made regarding call light response from nursing staff. It stated that staff would come into the room to turn the call light off and not assist with their needs. During an Interview on 2/18/26 at 10:05 a.m., Resident #1's family member revealed that staff do not answer call lights within a timely manner. Resident #1 family member stated that it had taken 45 minutes for staff to answer call lights also on rounding it had taken over two hours for staff to attend to her mother. Resident #1's family member stated there were no negative outcomes to Resident #1 due to the long wait. Resident #1's family member stated she had reported this to the DON and Administrator on 02/09/2026. Resident #1's family member stated that both the Administrator and DON were new and they informed her they were actively trying to hire additional staff and have let go of staff that did not want to perform their duties. Record review of facility grievance log for month of January 2026 revealed on 01/04/2026 a concern related to call light response time. Resolution revealed staff in-service. Record review of facility grievance log for month of February revealed on 02/09/2026 a concern related to call light response time. Resolution revealed staff in-services on call light response and rounding. During an Interview on 02/19/26 at 10:30a.m., Resident #4 stated that it takes staff up to an hour to respond to her call bell. She stated that it had happened on all shifts, but not every day, it depended on who worked that shift. She could not provide names of staff who took long time to answer call lights, During an interview on (continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>02/19/2026 at 1:25p.m., Resident #3 stated that the staff were slow at responding to call lights. Resident #3 stated that she had waited up to an hour before someone had come but could not state a date. Resident #3 stated that she had not reported this to anyone, just figured they would get to me when they could. She stated that the facility had recently gotten a new Administrator and DON and was told they were actively trying to hire new staff and get rid of staff who did not want to perform their duties properly. During an interview on 02/19/2026 CNA B revealed that he received inservice on documentation, call lights, when he first started working at facility approximately 3 weeks ago. He stated that he received complaints from residents regarding call light response. He stated that when he had received the complaint, he would take care of the resident request. He stated the expectation to respond to call lights was within 2-3 minutes. He stated that he does have to answer call lights on all hall. He could not state how long the light had been on for, just try to assist the resident. In an interview on 02/19/2026 at 12:43p.m., the DON stated she expected her staff to answer call lights timely. The DON stated that she wanted all staff to answer call lights and if they could not take care of the problem, they needed to get someone who could. The DON said the call light should never stay on longer than five to seven minutes and anything over that time was too long. The DON said there was no reason that the staff should not answer the call lights or go in and turn the light off without fulfilling the residents request. The DON stated that if a facility staff member could not fulfill resident request the resident light should remain on and that staff member was to go get someone who could assist. In an interview with Resident #8 on 03/04/26 at 1:10p.m., he stated he had just returned from dialysis. He stated CNAs were not available when he returned from dialysis. He stated it did no good if he pushed the call light, because the staff would not show up to see what he wanted. He stated he returned from dialysis around lunch time. He stated he was always told that they were passing out the trays on hall, and he would have to wait until all the lunch trays had been passed. He stated when he returned from dialysis, he was very tired and wanted to get into his bed. Observation on 03/04/26 at 1:30p.m., the Social Worker responded to the call light of Resident #8. The Social Worker was observed by investigator telling Resident #8 that the food trays were a priority for the staff and they would come to see what he needed once the last tray was passed. Observed Resident #8 inform the Social Worker he wanted his bed made so he could lay down. In an interview on 03/04/26 at 1:35p.m., the Social Worker stated on 03/03/26 Resident #8 had asked to change his room. She stated that later in the day he stated that he wanted to move back to the previous room. She stated that Resident #8's personal items were still in the room he moved from the second time. She stated she was explaining to Resident #8 that his personal items would be moved back to his room once the staff finished passing out the trays. She stated that his bed was made in the room that he left this morning, but it was not made in the room he moved back to yesterday. She stated that his family had requested to be present when his items were moved so that she could account for the items. She and a nurse got linen and made-up Resident #8's bed so that he could get into bed. In an interview on 03/04/26 at 2:40p.m., CNA G stated she was the only CNA working the hall on 03/04/2026 on the 6-2 shift. She stated if she saw the lights and she was busy she could ask someone to help her, she stated anyone could answer the call lights. She stated that she was assigned hall 600 and hall 400, the nurses were supposed to assist her with the residents. CNA G stated that when a call light was not answered in a timely manner it would place the residents at risk of not getting their needs met which could cause harm. Record review of facility In-service training attendance roster dated 02/6/26 reflected, Call Light Response time: Call lights should be answered promptly by any staff member. Call light is to stay on until need is met. Record review of facility In-service training attendance roster dated 02/6/26 reflected, Rounding and Repositioning: Changing [residents] position is imperative to the well being of the resident. It prevents skin breakdown and odors. Record review of the facility in-service on Rounding and Answering call lights dated 02/02/2026. Record review of facility policy titled Every 2 Hours Matters undated revealed the following: Rounding and Call light Responsiveness, why this is important.-Prevents falls, skin breakdown, and injuries-Reduces call light and resident (continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>complaints-improves resident comfort, dignity and safety Call light Expectations-Answer call lights promptly-never ignore or silence a call light without checking-if you cannot meet the need right away: Acknowledge the resident; Communicate clearly when you will return</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain medical records for 3 of 10 residents (Residents #2, #3 and #4) reviewed for accurate documentation. The facility failed to document wound care treatments for Residents #2, #3 and #4 as ordered by the physician This failure could place 3 residents with pressure injuries at risk of not receiving the care and services to meet their needs. Findings included: 1. Record Review of Resident #2's MDS dated [DATE] reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive skills for daily decision making are severely impaired. Her diagnoses include Dementia, Alzheimer's Disease, Stroke, and Malnutrition. The resident was dependent on staff for her repositioning to her back, left, and right side. Resident #2 was always urinary and bowel incontinent and dependent on staff for toileting hygiene. Record review of Resident #2's Care Plan dated reflected: Resident had pressure ulcers or potential for pressure ulcer development. Resident had a performance deficit Facility Interventions: Staff to ensure heels are floated with the use of pillows Staff to turn/reposition at least every 2 hours Staff to assist resident with bed mobility, dressing, and toileting. Record review of Resident #2's TAR dated February 2026 indicated Resident #2 did not receive her scheduled wound care on the following days: 2/7; 2/8; 2/11; 2/12; 2/13; 2/14; 2/15; 2/16; 2/20; 2/23. 2. Record Review of Resident #3's MDS dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His cognitive skills for daily decision were moderately impaired. His diagnoses included: Heart Failure, Malnutrition, Muscle Weakness, Difficulty walking, End Stage Renal Disease. Resident was always urinary and bowel incontinent and required maximal assistance with toileting hygiene. Record review of Resident #3's Care Plan dated 08/30/2024 reflected: Resident had a pressure ulcer or potential for pressure ulcer development Goal was for the resident will have intact skin, free of redness, blisters or discoloration Interventions were as follows: Administer medications as ordered. Monitor/document for side effects and effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Incontinent care after each episode and apply moisture barrier Notify nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care. A TAR dated February 2026 indicated Resident #3 did not receive his scheduled wound care on the following days: 2/7/2026; 2/8/2026; 2/9/2026; 2/11; 2/12; 2/13; 2/14; 2/15; 2/16. 3. Record review of Resident #4's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making are intact. Her diagnoses include Type 2 Diabetes, Difficulty Walking, Muscle Weakness, Heart failure, and Protein-Calorie Malnutrition. Resident #4 was always incontinent in urinary and bowel continence and dependent on staff for toileting. Record Review of Resident #1's care plan dated 12/18/2025 reflected: Resident #1 had potential for pressure ulcer development; decreased mobility. Goal: will have intact skin, free of redness, blisters or discoloration. Interventions: Follow facility policies/protocols for the prevention of skin breakdown The resident needs assistance to turn/reposition at least every two hours. A TAR dated February 2026 indicated Resident #1 did not receive her scheduled wound care on the following days: 2/11; 2/12; 2/13; 2/15; 2/16; 2/23. During an interview on 02/19/26 at 11:44a.m., ADON A revealed that she was currently the treatment nurse for the facility and that the facility expectation was that staff were to chart a treatment was completed in a residents medical administration record. ADON A stated that if there were missed wound care treatment dates on the medical administration record it did not mean that the staff did not complete the task. ADON A stated that that it the staff member may have been forgotten, but as a nurse and according to the DON expectation if it is not documented it was not completed. ADON A stated one way to tell if the wound care was completed was by the date and initial on the bandage or you can tell by the wounds that (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>have healed or resolved. During an interview on 02/19/26 at 12:43p.m., the DON revealed that her expectations of staff were to document that they completed the task at least once per shift. The DON stated that if the documentation was not in electronic health record it meant one of three things that they completed the task and forgot to chart, or that the staff member did not perform the task, or that the resident was independent and did not require our assistance. The DON stated that if it was not charted it did not happen. The DON stated that the risk to the resident when staff do not document wound care residents pressure sores can get larger, infected, or prevent healing. During an interview on 02/19/2026 at 4:35p.m., the Administrator stated that his expectations of clinical staff were document care that was provided once per shift. The Administrator stated that if dates were missed on wound care it meant the wound care did not happen. The Administrator stated that the harm and risk to the resident when staff do not document wound care for resident was that the resident could develop skin break down, pressure wounds, get an infection, or prevent healing. The Administrator stated the facility had in-serviced staff on documentation on 02/06/2026. Record review of in-service dated 02/06/2026 which included the following topics: Documentation Prevention of Pressure Ulcers Recognizing Change of Condition Rounding and Repositioning Call Light Response Time Record review of facility policy titled Pressure Injury: Prevention, Assessment and Treatment with revised date of 05/05/2025 revealed 6. Nurse Action/Rationale. 1. Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions; 1. Determine resident's skin tolerance to pressure and develop a turning schedule; resident should be turned every two hours or more often if necessary and notify the Treatment Nurse/designee of any potential problems. 10. Treatment Nurse/designee of DON will assess site and evaluate for appropriate stage as listed in this procedure. Sign off on treatment sheet any treatment completed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1 (Resident #2) of 5 residents. The facility failed to ensure CNA A performed hand hygiene during incontinence care for Resident #2. This failure placed residents at risk for healthcare associated cross contamination and infections. Findings: Record Review of Resident #2's MDS dated [DATE] reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive skills for daily decision making are severely impaired. Her diagnoses include Dementia, Alzheimer's Disease, Stroke, and Malnutrition. The resident was dependent on staff for her repositioning to her back, left, and right side. Resident #2 was always urinary and bowel incontinent and dependent for toileting hygiene. Review of Resident #2's Care Plan dated 12/04/2025 reflected: Resident had pressure ulcers or potential for pressure ulcer development. Goal Pressure ulcer will show signs of healing and remain free from infection. Facility Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #2's skin assessment dated [DATE] revealed that Resident #2's skin was intact. Resident #2 had a moderate/high risk for skin breakdown due to incontinence of urine and stool. On December 2, 2025 nurse practitioner was consulted for 3 new pressure ulcers discovered on resident's right heel and left toe. On January 20, 2026 new pressure ulcers were discovered on resident's left foot, right 4th toe, left big toe, and on right and left heels. On February 3, 2026, a new sacral pressure wound was discovered. During an observation on 2/18/26 at 1:30p.m. of Resident #2 revealed CNA B performed incontinent care. Resident #2 was lying on her left side with her eyes closed and non-verbal. Resident #2 responded to verbal stimulation. CNA B washed his hands and put on gloves. CNA B removed the brief, moved Resident #2 to her back and cleaned the perineal area. As CNA B cleaned Resident #2's perineal area he used the same soiled wipe to wipe her perineal area multiple times. Afterwards, CNA B used his soiled, gloved right hand to pull up his left sleeve before going back to incontinent care. During an interview on 02/19/2026 at 11:23a.m., CNA B revealed that he was not aware that he reused the same wipe when he performed incontinent care on Resident #2. He also stated that he did not realize he had adjusted his personal sleeve with soiled glove then continued to perform incontinent care without changing glove. CNA B stated that was not the facilities standard practice and was able to correctly state the correct way to perform incontinent care on residents. CNA B revealed he had received in-service on Infection Control prior to being able to work the floor three weeks ago. During an interview on 02/19/2026 at 12:43p.m., the DON, revealed staff were supposed to use one wipe then discard soiled wipe and get a new wipe to continue incontinent care and repeat until resident were clean. The DON stated they only used one clean wipe at a time to prevent infection. The DON stated that during incontinent care, staff should perform hand hygiene after they touch any part of their clothing, because there could be something on the staff's clothes. Record review of the facility policy Fundamentals of Infection Control Precautions undated revealed the following: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene-After handling soiled or used linens, dressings</p>		