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	03/13/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #6) out of 6 residents reviewed for accidents and supervision.The facility failed to ensure CNA-A used proper fall procedures on 3/2/26 when Resident #6 slid from her wheelchair while being loaded into the transportation van by not contacting a nurse to assess the resident immediately.The facility failed to ensure Resident #6's safety when CNA-A drove back to the facility with the resident sitting on the van floor unsecured.These failures could place residents at risk for falls, injuries, and a decline in health.Record Review of Resident #6's face sheet revealed she was a [AGE] year-old female who was admitted on [DATE]. Her diagnoses included: Displaced Supracondylar Fracture without Intracondylar extension of lower end of left femur (lower thigh bone breaks just above the knee joint), Other Sequelae of Cerebral Infarction (long-term residual neurological and functional deficits persisting after a stroke), Muscle Weakness, Lack of Coordination, Sickle Cell Anemia (inherited blood disorder which causes pain, organ damage and infections), age related Osteoporosis (characterized by low bone mass, structural deterioration, and decreased density, making bones fragile and highly susceptible to fractures), and Cognitive Communication Deficit (caused by underlying cognitive impairments such as memory, attention or executive function deficits). Record Review of Resident #6's Admissions MDS dated [DATE] revealed a BIMS of 11 which meant moderate cognitive impairment. Resident #6's MDS revealed she used a wheelchair and a manual lift (a mechanical device used to lift a wheelchair for transportation). She needed some help with self-care, indoor mobility, and functional cognition. Resident #6 had impairment of her lower extremities on both sides. Record Review of Resident #6's Care Plan dated 3/3/26 revealed she was at risk for falls due to decreased mobility/unstable balance,, and had a potential for uncontrolled pain due to Sickle Cell Disease and history of fracture. Record Review of the PIR dated 3/6/26 revealed the incident occurred on 3/2/26 around 6:30 p.m. The Admin. notified and it was reported to HHSC on 3/3/26 at 8:22 a.m. The PIR stated Resident #6 was loaded into the facility van by CNA-A after an appointment. Resident #6 slid out of her wheelchair when the van was parked. CNA-A assisted Resident #6 to the van floor. Resident #6 stated she had dull pain to her left thigh. The facility notified Resident #6's family, and physician about the incident. The physician ordered x-rays be completed. The x-rays showed a possible fracture of the left thigh; the physician was notified and sent Resident #6 to the hospital for evaluation. The hospital found no new fractures in Resident #6's left leg and she returned to the facility the same day. The facility started in-service training for all staff on Abuse and Neglect, Fall Preventions/Fall Risk, Incident/Accident notification, and Notification of Change of Status. The facility conducted safe surveys with no concerning results. The facility interviewed and suspended CNA-A pending investigation. The facility in-serviced CNA-A on Employee Auto Training Handbook on 3/3/26. The facility removed the van from service until a full inspection could be completed using outside transportation companies until a trained and qualified driver was identified. Record Review of the facility's Incidents By Incident Type Log, dated 3/12/26 revealed Resident #6 had a Fall Incident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/2/26 at 5:36 p.m. Record Review of Resident #6's Progress Notes on 3/2/26 at 7:30 p.m. written by the LVN revealed Resident #6 slid out of wheelchair and assisted to the floor by staff. Resident was assisted back into the wheelchair by staff. Appears and/or states to be in pain. Describes the pain as: Dull, Location of pain: left thigh pain relieving intervention used at this time: prn pain medication.Resident statement: Resident stated she slid out of chair. Record Review of a Witness Statement dated 3/2/26 by CNA-A stated revealed, I loaded [Resident #6] in the van as I pulled her chair in [Resident #6] begin to slide out her chair and I guided her to floor. I then transported her back to the facility. Record Review of a Witness Statement dated 3/2/26 by the LVN stated revealed the van driver came into the building and said she needed help getting a resident up that slid out of her chair. The resident was assessed and was cleared to get put back into her wheelchair and returned to her room. I then performed a full head to toe assessment with no new injuries noted. The resident stated (sic) having a dull pain that was not a new pain for her. I place a pillow in the spot she asked me to and she said that felt better. Record Review of a Witness Statement dated 3/2/26 by the Admin stated revealed On 3/2 I was informed by nursing that a resident fell while out on a transport and was now back in her room. I was informed that the driver came in and asked for help getting the resident up due to her being on the floor of the van. I was informed that while loading a resident [#6] onto the transportation van the resident began sliding and the driver assisted her to the floor. She [CNA-A] then drove the van back to the facility with the resident in the floor of the van. The driver stated that the resident was a two person lift and she was not able to lift by herself. She stated that she knew that the resident was a two person lift and she was not able to lift by herself. She stated that she knew that she should have called for help and was trained on when to call for assistance. When I asked her why did she not call for assistance her response was, I am not sure. I knew I should have but chose the wrong decision. Record Review of Resident #6's Progress Notes on 3/3/26 at 6:45 a.m. written by the RN revealed Report received that resident slid out of wheelchair yesterday in the Transportation Van coming back from The Doctors [sic] appointment. Radiology report received this morning and sent to Doctor, Manager called in this morning to send resident to the hospital and a message came in from the Doctor as well to send resident to the hospital too. Paramedics called in and resident was transported to the Hospital. Record Review of Resident #6's discharge paperwork on 3/3/26 from the hospital findings revealed No acute fractures are present in this patient. Interview on 3/12/26 at 10:17 a.m. with the Admin. stated CNA-A was transporting Resident #6 from her appointment when she slid out of her wheelchair. He stated CNA-A got a nurse to assess and get Resident #6 back in her wheelchair. Interview on 3/12/26 at 12:19 p.m. with the RN stated if a CNA found a resident on the floor, they should get a nurse immediately. The nurse would assess the resident to see if they could get up or if they needed to call 911. The RN stated she would inform the MD and FM of the fall. The RN stated she was not working at the time but heard Resident #6 slid out of her wheelchair coming back from an appointment. She stated they did x-rays and they showed an old injury, but the MD still gave orders to have her sent to the hospital. The hospital confirmed there were no new fractures and Resident #6 returned to the facility the same day. Interview on 3/12/26 at 2:45 p.m. with Resident #6 stated she had an appointment, the driver used the lift to get her wheelchair in the van. Resident #6 stated she started to slip, while she was in the van and the driver helped her to the floor. She stated the driver left her on the floor and she drove back to the facility. Resident #6 stated she hurt her leg, but it was broken before the incident. She had not seen CNA-A since the incident. Interview on 3/13/26 at 10:30 a.m. with the Admin stated Resident #6 was going up into the van on her wheelchair when she slipped out and the aide helped her back into her wheelchair. He stated x-rays were done and they saw the old fracture from around November 2025. The Admin stated Resident #6 was sent out to the hospital, and they reported no new injuries, only the old break. The Admin stated he had terminated CNA-A due to the incident. Attempted interview on 3/13/26 at 11:49 a.m. to with CNA-A by telephone. A , a message was left requesting a return call. No return call was received to date. Interview on 3/13/26 at 11:53 a.m. with CNA-B stated she did (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transportation training on how to load and unload a resident. She stated you they must load the resident at the back of the ramp, push them up and hook the latch at the back of the wheelchair and put the seat belt on. CNA-B stated she heard about CNA-A reportedly loading Resident #6 into the van when she started sliding. She heard CNA-A kneeled Resident #6 to the ground. CNA-B stated she would have gone back into the doctor's office for help or would have called 911. She heard CNA-A called when she got back to the facility for the nurse to help get her back in her wheelchair. Record Review of the facility's Safe Patient Handling, undated revealed The facility has a program to promote and assure safe patient handling for both the resident and the employee. The policy includes identification, assessment, and interventions to provide a comfortable safe transfer, repositioning, and resident movement. 6. Facility staff will report to supervisor the inability to complete resident lifting, transfer, or repositioning if they feel it will either endanger the resident or cause injury to staff. Record Review of the facility's Fall Risk Assessment dated 2/1/2007 revealed under 13. In the instance where fall risk measures do not prevent a fall, the resident will be assessed immediately for injury. Vital signs and first aid measures will be completed immediately. The Charge Nurse will notify the attending physician and family member as soon as possible after the resident has been stabilized. Record Review of the facility's Employee Auto Training Handbook undated revealed under Safety 1. Safety must always be our priority. 2. Employees will comply with all safety laws. 3. It is the responsibility of each of us to ensure that our organization operates safe equipment on our highways. Additionally, we must carry out assigned duties in a safe manner.