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	04/19/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 4 of 4 residents (#20, #26, #45, #49) reviewed for activities in that: Residents #20, #26, #45, and #49 were not provided activities since AD's last day of employment on 03/16/2024. The facility currently did not have an AD on staff. This deficient practice could affect all residents who required activities and could result in decline in social and mental psychosocial well-being . The findings were: Review of Resident #49's face sheet, dated 04/18/2024, revealed he was admitted on [DATE]. Resident #49's diagnoses included Unspecified Sequelae of Unspecified Cerebrovascular Disease (a condition that affects blood flow in the brain); Essential (Primary) Hypertension (High Blood Pressure); Hemiplegia and Hemiparesis Following Other Cerebrovascular Disease Affecting Unspecified Side (Paralysis of partial or total part of the body function on one side of the body). Review of Resident #49's Comprehensive Plan of Care, initiated 01/05/2022, revealed Resident #49 will express satisfaction with type of activities and level of activities. Review of the interventions revealed CNAs will modify resident's daily schedule, treatment plan prn to accommodate activity participation. Review of Resident #49's Quarterly MDS assessment, dated 03/19/2024, revealed he was cognitively intact and needs supervision to touching assistance with his activities of daily living. The facility Activity Assessment on file dated 08/02/2023, for Resident #49 indicated he enjoyed going to activities with groups and musical programs. (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

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 04/19/2024

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

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Interview with Resident #49 on 04/18/24 at 10:43 AM revealed the last AD would have several activities scheduled everyday. Resident #49 mentioned he would like to have a birthday party. The residents missed their birthday parties. Resident #49 said he would like to see the facility have musical programs, birthday parties, corn hole, and arts and crafts. Resident #49 stated he was not aware of the musical program that was held yesterday afternoon with gospel music and preaching. Resident #49 revealed that the facility cannot keep an AD because of the budget or they do not pay them enough. Resident #49 admitted his family member takes him out on pass to eat and brings other family members by to see him. Resident #49 revealed that helps with the boredom of not having anything to do.

Review of Resident #26's face sheet, dated 04/18/2024, revealed she was admitted on [DATE]. Resident #26's diagnoses included Personal History of Malignant Neoplasm of Brain (Cancerous brain tumors); Epilepsy, Unspecified, Intractable, With Status Epilepticus (Seizures that can't be completely controlled by medications); Essential (Primary) Hypertension (High Blood Pressure).

Review of Resident #26's Comprehensive Plan of Care, initiated 02/02/2024 and revised 02/12/2024, revealed Resident #26 will attend/participate in activities of choice. Review of the interventions revealed activity director will provide a program of activities that is of interest.

Review of Resident #26's Quarterly MDS assessment, dated 03/29/2024, revealed she was cognitively intact and needs moderate/substantial assistance with his activities of daily living.

The facility Activity Assessment on file dated 02/16/2024, for Resident #26 indicated she enjoys going to activities with groups, musical programs, going outside for fresh air, reading, and attending church services.

Interview with Resident #26 on 04/18/24 at 11:31 AM revealed that she would attend some of the activities when there was an Activity Director. Resident #26 would attend Church group that came twice a week, but then the group stopped coming. Resident #26 attended the Gospel Music and speaker on 04/17/2024 after Resident Council Meeting. Resident revealed that she stays in her room most of the time. She likes to play on her I-Pad most of the time because there have not been any activities to attend without an Activity Director.

Review of Resident #20's face sheet, dated 04/18/2024, revealed he was admitted on [DATE]. Resident #20's diagnoses included Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (Caused by plaque buildup in the wall of the arteries that supply blood to the heart) ; Parkinson's Disease (Disorder of the central nervous system that affects movement, often including tremors); and Schizoaffective Disorder, Bipolar Type (A mental illness or mental episodes of feelings of euphoria, racing thoughts, increased risky behavior and other symptoms of mania).

Review of Resident #20's Comprehensive Plan of Care, updated 10/17/2022 and revised 03/15/2024, revealed Resident #20 will attend activities of choice. Review of the interventions revealed activity director will encourage and remind resident of activities.

Review of Resident #20's Quarterly MDS assessment, dated 03/14/2024, revealed he was cognitively intact and needs supervision with his activities of daily living.

The facility had no Activity Assessment on file in Resident #20's medical file to review.

(continued on next page)

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

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #20 on 04/18/24 at 12:46 PM revealed that the activities were being held and there would be at least 15 - 17 residents to attend the programs. There had been several ADs in the last 2 years the facility has been opened. The AD left to have her baby back in March and she was not returning. Resident #20 had held bingo for the residents. He revealed that the store was taken away from the residents for the bingo prizes. Resident revealed that his family member bought the last prizes for bingo store, but resident states that the Administrator stopped having the store for the prizes. Playing bingo, attending church and musical programs are his favorite programs. All Resident #20 does most of the day is watch TV. Resident #20 said that no one likes to play Dominoes. Interview with SW on 04/18/2024 at 10:10 AM the SW revealed the AD last worked there 3/16/24. The facility has been without someone to lead activities. The SW revealed that no other department heads have held any activity programs for residents. The SW revealed that there is a Church group that comes in. An individual came in yesterday (4/17/24) from one of the churches to hold gospel music time and preaching. There were only about 5 or 6 residents in the activity. The SW revealed that there was a sister facility in another city, but not sure on groups who could come in from there to hold activities. Interview on 04/18/2024 at 11:40 AM with the Administrator confirmed that he has been without an AD since March and has interviewed for a new Activity Director and hoped to offer the job to the applicant today. The Administrator had hired a new AD that was to begin work on Monday, 04/15/2024 but did not show up for the job. The Administrator revealed prizes for bingo has not been stopped. The prizes will resume, but in a more efficient way to be fairer to all the residents who win. Review of Resident #45's admission record, dated 04/18/24, reflected she was a [AGE] year-old female, admitted [DATE], with diagnoses of stroke, broken femur, diabetes, Bell's palsy (a condition causing one side of the face to droop), major depressive disorder, heart failure, and dependence on renal dialysis. Review of Resident #45's quarterly MDS assessment, dated 02/28/24, reflected Resident #45 was sometimes understood by others, and was able to understand others and had severely impaired vision. Resident #45 had a BIMS of 14, indicating intact cognitive function. Resident #45 had no behaviors, and no indicators of psychosis or depression, and rarely felt socially isolated. She used a wheelchair and had one-sided impairment of her lower body. Resident #45 was incontinent of bowel and bladder, and required supervision or touching assistance with eating, and required substantial to complete assistance of staff for most other ADLs, like dressing, bathing, and hygiene. She was dependent on staff to move her in her wheelchair. Review of Resident #45's care plans reflected: The resident needs in room socialization and sensory stimulation; Date Initiated: 03/01/2023; Revision on: 03/01/2023: Resident will respond to one on one in room visits with sensory stimulation such as tactile, and visual in room activities. Date Initiated: 03/01/2023; Target Date: 06/02/2024. The activity director will provide the resident with one on one [sic] visits with sensory stimulation at least 3 times per week Date Initiated: 04/11/2023. Review of Resident #45's care plans reflected no care plans which addressed out of room activity options or preferences. (continued on next page)

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

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes for 01/30/24 through 04/17/24 reflected no notes regarding Resident #45 attending activities. An interview and observation on 04/16/24 at 10:07 AM with Resident #45 revealed her to be fully dressed with her coat on, seated in her wheelchair, waiting for someone to take her to dialysis. She was friendly and talkative, and said that she liked the facility, and the staff, and had few complaints, but did not like her roommate at all. An interview on 04/17/24 at 4:17 PM with Resident #45 and Resident #45's family member revealed that when Resident #45 first got to the facility she used to be taken to meetings, and church services. Resident #45 said that someone used to come and get her, and take her to some activities, and though she did not want to go to all of them, because she was blind, and could not walk, she would like to go to church services, and maybe music activities sometimes. She said that when she became blind, and stopped being able to walk, she stopped doing some things she liked to do. Her family member said that the facility had two activity directors that she knew of, and that Resident #45 used to be taken to a lot of activities, but it suddenly stopped, and she did not know why, but she did not go to any of them anymore. Resident #45 said nobody asked her if she wanted to go to things anymore. On 04/19/2024 at 12:22 PM, requested policies and procedures for Activity Program from Administrator. Informed by the Administrator during a conference on 04/19/2024 at 1:00 PM the facility does not have an activity policy. The facility follows the CMS guidelines required for the activity program. 44894

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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 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** 48329 Based on observation, interview, and record review, the facility failed to ensure each resident's environment remained as free of accident hazards as is possible, and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #16) of five residents reviewed for accidents. The facility failed to ensure the safety of Resident #16 by not assisting with the consumption of hot liquids and meals, which caused him to spill coffee over himself during the breakfast meal on 04/17/24. This could affect residents by placing them at risk for injuries that could be prevented. Findings included: Review of Resident #16's admission record, dated 4/16/24, revealed he was admitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke), multiple sclerosis, tremors, unspecified lack of coordination, muscle weakness and conversion disorder with seizures or convulsions. Review of Resident #16's quarterly Minimum Data Set (MDS) assessment, dated 3/1/2024, revealed resident was moderately cognitively impaired with a BIMS score of 09. His MDS revealed his functional abilities for eating required supervision or touching assistance. Helper provides verbal cues and or touching steadying and contact guard assistance as resident completes activity. Review of Resident #16's Comprehensive Care Plan, accessed on 4/16/24, revealed that alteration in musculoskeletal status r/t contracture (permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) of left hand was initiated 3/6/2023. The resident has an ADL self-care performance deficit initiated 2/24/2023. eating required staff assistance. Review of Resident #16's Comprehensive Care Plan, accessed on 4/16/24 revealed that the resident has hemiplegia/hemiparesis (paralysis) r/t weakness on one side. Initiated on 02/24/2023. Interventions included assist with ADL/Mobility as needed. Reposition at least every two hours. Observation on 4/17/2024 at 8:14am of Resident #16 revealed he was in bed at this time with breakfast in front of him on the bedside table. Resident #16 was observed to have trouble connecting food to mouth. Resident #16 grabbed coffee cup off the bedside table to take a sip but when returning the cup to the bedside table, he spilled coffee over himself and table due to unsteady hand. Observation did not reveal steam rising from the coffee. The resident did not indicate pain. Observation revealed no staff in the room providing the resident assistance during the meal. Interview with DON on 4/17/2024 at 8:25am revealed there was supposed to be a lid over the coffee cup. DON stated that she would conduct a burn assessment as well as get resident cleaned up. The DON stated she was unaware that no one was in the room with Resident #16. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 10:12am with Resident #16's family, she stated it was a common issue that she had with the facility. She stated on Monday (04/15/24) he spilled hot soup on himself, and she has asked over and over if he could have assistance, but she feels it was a staffing issue. She also stated before his stroke the resident was left-handed so now the resident was trying the best he could to use his right hand but was dealing with the MS which limited his ability. She stated that the resident did not want to be a bother, so he did not call for help. The family member stated he just will not eat or would keep trying to do so despite spilling it on himself. Surveyor came with her to assess and revealed he did not have any burns. Resident #16's family stated the resident stated that the coffee was not hot, it was only warm. He stated that it would be nice if he could get some assistance, but he knows everyone is not always available. Review of Resident #16's hot liquid assessment dated [DATE], revealed resident had weakness/paralysis to upper extremities. Resident could not consume hot liquids/foods without special interventions. Interventions to decrease potential burns with coffee or other hot liquid include lids on cups, staff provide observation and verbal assistance while handling hot liquids, should be seated in upright position with table or overbed table. Review of the facility's document titled Assisted with meals (600 hall) revealed Resident #16 was listed as a resident needing assistance with meals. Observation and interview on 4/17/2024 at 10:15am with RN D revealed Resident #16 lying in bed drinking a cup of coffee. Resident #16's shirt was open, revealing the top half of his chest. No burns or redness was observed. Resident denies any pain or discomfort currently. Asked resident, if the coffee had burned his skin he responded, No it was warm, not hot enough to burn me, thanks for asking. Interview with CNA A on 4/18/24 at 11:42 AM revealed the CNA stated that she fed Resident #16. She said he needed assistance and if left to himself, he will spill food. Interview on 4/18/2024 at 10:51am with COTA C stated that he did not do the assessment for determining feeding assistance. He stated he has worked with Resident #16 before on wheelchair tolerance, Geri chair and tolerance and range of motion to the left side. He stated he did speak with evaluator K yesterday (4/17/24) due to the left hand noticing a contraction, although he does have range of motion. COTA C said he would be ordering a sling for that. He stated therapy typically would come in when a resident needed help in eating. He stated he had observed Resident #16 eating and before the resident was able to pick up a cup and fork with no problem. From COTA C's observation the spill came from the resident not having a lid on the cup, because when he came in to observe Resident #16, the resident was able to pick the coffee cup up and down without an issue. If there was an issue, he would have recommended a universal cup. COTA C stated from a therapy standpoint therapy's goal was to keep the residents' independence as much as possible. Staff usually will let therapy know if the resident had declined. COTA C stated evaluator K did the assessment for feeding assistance. Observation on 4/19/2024 at 9:15am Surveyor tasted coffee served in the dining room which is always available for residents. Coffee was warm to the touch and able to sip from cup. The DM stated this coffee was put out at 7:00am. She said it was brewed in the back to 200 degrees but is not allowed to be served until it cools down and they temp it at 140 degrees Fahrenheit and serve it. (continued on next page)

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy, Daily Food Temperature Control ., undated, .We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log. This is done to help ensure that food is safe and is served within acceptable ranges .Hot Liquid / Food Spills .Residents are at risk of having any hot liquid/food spilled on their person causing burns. Examples of hot liquids/food are coffee, tea, hot soup, oatmeal, or any other hot food or liquid substance.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 49733 Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications from enteral feeding for 2 of 2 resident reviewed for enteral feeds (Residents #6 and #36). The facility failed to check for residual volume prior to medication administration for Resident #6 and Resident #36. The facility failed to flush G-tube between and after medication administration for Resident #36. The facility failed to ensure that Resident #36's head of bed was maintained at 30 degrees elevated during medication administration. The facility failed to ensure medications were administered through gravity method for Resident #6 and Resident #36. These deficient practices could place residents receiving enteral nutrition and medications at increased risk of aspiration, infection, bloating discomfort, tube occlusion (blocked fallopian tubes), and not receiving the full benefit of the medications administered. The findings included: Review of Resident #6's face sheet, dated 04/17/24, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE]. Her diagnoses included Gastrostomy status (an opening in the stomach at the abdominal wall made surgically to introduce food), dementia, Alzheimer's, dysphagia (difficult swallowing). Review of Resident #6's quarterly MDS Assessment, dated 04/17/24, revealed Resident #6's BIMS score was blank which indicated severe cognitive impairment. Resident # 6 required extensive to total assistance with activities of daily living with two persons assist. Further review revealed Resident #6 had a feeding tube. Record review of Resident #6's medication administration and treatment record revealed an order with a start date of 04/01/24 - 04/30/24 which indicated, Enteral Feed Order, every shift Check residual before medications and feedings; return contents after each check. Enteral Feed Order every shift Flush with at least 5mls of water between each medication via g/t. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/17/24 at 09:20 AM revealed LVN E administering medication s to Resident # 6 via the feeding tube. LVN E crushed medication and placed in separate medication cups and then mixed with 5 - 10cc of water. LVN E informed Resident #6 she was going to administer her medication, then LVN E positioned the resident and paused the feeding pump and disconnected the resident from the feeding pump. LVN E then flushed the feeding tube with 30 cc of water by pushing with a syringe and she did not check for residual. LVN E then administered all the medication by pushing with the syringe and flushing in between with 5 cc of water. After medication administration LVN E flushed the feeding tube with 30 cc of water by pushing with the syringe. In an interview on 04/17/24 at 09:42 AM with LVN E she had initially stated she was not supposed to check for residual, but when she checked the orders, she then stated she was supposed to check for residual. LVN E stated she was supposed to check for residual to make sure the resident's feeding was being digested without any issues and she was not being overfed. She stated when the stomach had too much volume it could lead to the resident vomiting which could lead to aspiration. Regarding pushing fluids with the syringe, LVN E stated she was supposed push the water with the syringe and that there was no order not to push fluids or medication. LVN E stated she was not aware what the facility policy discussed about pushing medication and water flushes via a feeding tube. LVN E stated she had been in-serviced on medication administration via the feeding tube but did not remember when. Record review of Resident #36's Face Sheet, dated 4/16/24, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified Intracranial Injury without loss of consciousness (damage within the skull or brain that occurs without the affected person losing consciousness), unspecified Protein-Calorie malnutrition (imbalance of essential nutrients from your food and drinks, leading to inadequate protein and calorie intake), Aphasia (a comprehension and communication disorder resulting from damage or injury to the specific area in the brain), and encounter for attention to Gastrostomy (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression). Record review of Resident #36's MDS assessment, dated 3/05/24, revealed the resident was non-verbal and had impaired cognitive and mental status. The BIMS score was blank. Record review of Resident #36's Care Plan, completed on 3/15/24, revealed: Resident G -tube came out and was sent to hospital for replacement. Date initiated: 5/15/23. Related interventions: The resident needs the HOB elevated 30 degrees during and thirty minutes after tube feed. Intervention initiated 3/17/23. The resident has potential fluid deficit related to feeding tube. Date initiated: 3/17/23. Revised on: 6/19/23. Related interventions: Administer enteral feeding and flushes/fluids per G-tube as ordered; Administer medications as ordered. The resident has an alteration in neurological status related to brain injury. Date initiated: 3/17/23; Revised on: 6/19/23. Related intervention: Give medications as ordered . The resident has GERD . Date initiated 3/17/23. Revised on 6/19/23. Related interventions: Give medications as ordered . (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has potential nutritional problem related to dysphagia (difficulty in swallowing); feeding tube in place. Date initiated: 3/17/23. Revised on: 6/19/23 and 10/06/23. Related interventions: Administer medications as ordered . Record review of Resident #36's Order Summary Report, accessed on 4/16/24, revealed the following: Baclofen Oral Tablet 5 MG (Baclofen). Give 1 tablet via G-Tube two times a day. Order date: 12/27/23, no end date. Citalopram Hydrobromide Oral Solution 10 MG/5ML (Citalopram Hydrobromide). Give 5 ml via G-Tube one time a day. Order date 7/08/23, no end date. Famotidine Tablet 20 MG. Give 1 tablet via G-tube two times a day. Order date: 3/10/23, no end date. Gabapentin Oral Solution 300 MG/6ML (Gabapentin). Give 6 ml via G-tube two times a day. Order date: 4/03/24, no end date. Levetiracetam Oral Solution 100 MG/ML (Levetiracetam). Give 10 ml via G-tube two times day. Order date: 6/20/23, no end date. MiraLax Oral Powder 17 GM /SCOOP (Polyethylene Glycol 3350). Give 1 scoop via G-tube two times a day. Mix with at least 4-8 ounces of water. Order date: 9/23/23, no end date. Multivitamin Adult (Minerals) Oral Tablet (Multiple Vitamins with minerals). Give 1 tablet via G-tube one time a day. Order date: 3/04/24, no end date. Zyrtec Allergy Oral Tablet 10 MG (Cetirizine). Give 1 tablet via G-tube one time a day. Order date: 7/08/23, no end date. NPO diet. Start date 3/07/23, no end date. Enteral Feed Order every shift Check placement prior to feeding and medication administration. Start date 3/06/23, no end date. Enteral Feed Order every shift Check residual before medications and feedings; return contents after each check. Start date 3/06/23, no end date. Enteral Feed Order every shift Flush tube with 60ml water before and after medication and feedings. Start date: 3/06/24, no end date. Enteral Feed Order every shift Flush with at least 5mls of water between each medication. Start date: 3/06/23, no end date. Enteral Feed Order every shift Head of bed up at least 30 degrees during administration of enteral formula or water. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of medication pass on 4/17/24 at 9:47 AM revealed RN D at her medication cart preparing medications for Resident #36 to be administered via G-tube. RN D dispensed one of each of the following medications into a small paper cup for each tablet and liquid: Famotidine 20mg tablet Baclofen 5mg tablet Daily Vitamin tablet Cetrizine 10mg tablet Clear Lax 1 capful Gabapentin Solution 6ml Continued observation revealed RN D placed each medication into a plastic sleeve and crushed each medication separately then combined the medications in a cup. She put crushed medications into one cup, mixed them with 30 ml of water and she put each liquid medications into cups. RN D entered Resident #36's room and flushed his G-tube with 60 ml of water via push method (pushing medications with a syringe) without checking for residual. The nurse administered the crushed medications/water mixture through the G-tube via push. RN D administered the liquid medications via push then clamped the tubing without flushing after medication administration. Resident #36's head of bed was observed to be elevated approximately 10 degrees throughout the medication administration process. In an interview on 4/17/24 at 10:15 AM, RN D stated that during administration of medications through a G-tube, nurses were to check for residual. She stated she checked for residual. She stated the reason you check for residual is to make sure the resident does not have too much in their stomach. RN D stated that nurses should flush with water before, after, and in between medication administration. She stated she flushed the G-tube according to protocol. RN D stated it was important to flush during and after giving medications to ensure the medications are flushed completely and received by the resident. She stated the amount of water used for flushing the tubing depended on the resident's orders. RN D stated Resident #36's HOB should be elevated at 2 or 3 during nutrition and medication administration through G-tube. When asked to describe the HOB elevation in degrees, RN D stated she only knew that it should be at a 2 or 3. In an interview on 4/17/24 at 3:13 PM, the DON stated medications should not be mixed when giving medication through G-tube. She stated the combination of pills can have an ill effect on the resident and cause stomach issues. The DON stated that if medications were mixed, there was no way to determine which medications were given if the nurse was unable to complete the process of administering medications to the resident. The DON stated nurses were supposed to check for residual before giving any medications. She stated that if a resident's stomach was too full and medication was administered, it could lead to aspiration and vomiting. The DON stated nurses should flush before, between, and after administration of medications. She stated that medications were supposed to be given through gravity. If they are pushed, it can increase peristalsis (involuntary movements of the muscles in the digestive tract) in the stomach and cause diarrhea. The DON stated that residents who receive nutrition and medication through a G-tube should have their HOB elevated to at least 30 degrees during administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Enteral Medication Administration dated 1/25/13 revealed: 1. Check the placement of the tube by aspiration of contents or auscultation. Elevate the resident per facility policy. 2. Flush the tube with 30 ml water or according to physician order. 3. Administer one medication at time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered. 4. Once all medication has been administered, flush the tube with 30 ml water or according to physician order. 5. Do not force any medication or fluid into the tube. Allow gravity to work . Review of the facility's policy titled Gastrostomy Tube Care dated 3/02/21 revealed: 1. Unplug or unclamp the tube and check the placement by aspiration or injecting air and listening to the stomach for sounds. 2. Aspirate gastric contents with a 60 ml syringe and if the residual is less than 50% of last feeding or within guidelines of specific physician's order reinject aspirate and continue . 3. Maintain the resident in a semi (30 degrees) to high-Fowler's (60-90 degrees) position for 45-60 minutes following a feeding.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733 Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 22% based on 6 out of 27 opportunities, which involved 1 of 2 Residents (Resident #36) observed for medication administration, in that: The facility failed to ensure RN D administered medications to Resident #36 via G-tube according to the physician's orders and per standard of practice by crushing six different medications and combining them into one cocktail and pushing them through the G-tube instead of by gravity. These failures could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: Record review of Resident #36's Face Sheet, dated 4/16/24, revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified Intracranial Injury without loss of consciousness (damage within the skull or brain that occurs without the affected person losing consciousness), unspecified Protein-Calorie malnutrition (imbalance of essential nutrients from your food and drinks, leading to inadequate protein and calorie intake), Aphasia (a comprehension and communication disorder resulting from damage or injury to the specific area in the brain), and encounter for attention to Gastrostomy (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression). Record review of Resident #36's MDS assessment, dated 3/05/24, revealed the resident was non-verbal and had impaired cognitive and mental status. No BIMS score was specified. Record review of Resident #36's Care Plan, completed on 3/15/24, revealed: The resident has potential fluid deficit related to feeding tube. Date initiated: 3/17/23. Revised on: 6/19/23. Related intervention: Administer medications as ordered . The resident has an alteration in neurological status related to brain injury. Date initiated: 3/17/23; Revised on: 6/19/23. Related intervention: Give medications as ordered . The resident has GERD (gastroesophageal reflux disease). Date initiated 3/17/23. Revised on 6/19/23. Related interventions: Give medications as ordered . The resident has potential nutritional problem related to dysphagia (difficulty in swallowing); feeding tube in place. Date initiated: 3/17/23. Revised on: 6/19/23 and 10/06/23. Related interventions: Administer medications as ordered . Record review of Resident #36's Order Summary Report, accessed on 4/16/24, revealed the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Baclofen Oral Tablet 5 MG (Baclofen). Give 1 tablet via G-Tube two times a day. Order date: 12/27/23, no end date. Citalopram Hydrobromide Oral Solution 10 MG/5ML (Citalopram Hydrobromide). Give 5 ml via G-Tube one time a day. Order date 7/08/23, no end date. Famotidine Tablet 20 MG. Give 1 tablet via G-tube two times a day. Order date: 3/10/23, no end date. Gabapentin Oral Solution 300 MG/6ML (Gabapentin). Give 6 ml via G-tube two times a day. Order date: 4/03/24, no end date. Levetiracetam Oral Solution 100 MG/ML (Levetiracetam). Give 10 ml via G-tube two times day. Order date: 6/20/23, no end date. MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 1 scoop via G-tube two times a day. Mix with at least 4-8 ounces of water. Order date: 9/23/23, no end date. Multivitamin Adult (Minerals) Oral Tablet (Multiple Vitamins with minerals). Give 1 tablet via G-tube one time a day. Order date: 3/04/24, no end date. Zyrtec Allergy Oral Tablet 10 MG (Cetirizine). Give 1 tablet via G-tube one time a day. Order date: 7/08/23, no end date. Enteral Feed Order every shift Check residual before medications and feedings; return contents after each check. Start date 3/06/23, no end date. Enteral Feed Order every shift Flush tube with 60ml water before and after medication and feedings. Start date: 3/06/24, no end date. Enteral Feed Order every shift Flush with at least 5mls of water between each medication . Start date: 3/06/23, no end date. Observation of medication pass on 4/17/24 at 9:47 AM revealed RN D at her medication cart preparing medications for Resident #36 to be administered via G-tube. RN D dispensed one of each of the following medications into a small paper cup for each tablet and liquid: Famotidine 20mg tablet Baclofen 5mg tablet Daily Vitamin tablet Cetrizine 10mg tablet Clear Lax 1 capful Gabapentin Solution 6ml (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation revealed RN D placed each medication into a plastic sleeve and crushed each medication separately then combined the medications in a cup. She put crushed medications into one cup, mixed them with 30 ml of water and she put each liquid medications into cups. RN D entered Resident #36's room and flushed his G-tube with 60 ml of water via push method (using a syringe to the g-tube port and slowly pushing medications into the g-tube). The nurse administered the crushed medications/water mixture through the G-tube via push. RN D administered the liquid medications via push then clamped the tubing. Per physician order, Enteral Feed Order every shift Flush with at least 5mls of water between each medication . Start date: 3/06/23, no end date, RN D did not flush with at least 5 ml between each medication and instead combined all the medications into one. In an interview on 4/17/24 at 10:15 AM, RN D stated medications should be crushed separately but it was okay to combine medications for administration. RN D stated that nurses should flush with water before, after, and in between medication administration. She stated she flushed the G-tube according to protocol. RN D stated it was important to flush during and after giving medications to ensure the medications are flushed completely and received by the resident. She stated the amount of water used for flushing the tubing depended on the resident's orders. In an interview on 4/17/24 at 3:13 PM, the DON stated medications should not be mixed when giving medication through G-tube. She stated the combination of pills can have an ill effect on the resident and cause stomach issues. The DON stated that if medications were mixed, there was no way to determine which medications were given if the nurse was unable to complete the process of administering medications to the resident. The DON stated nurses should flush before, between, and after administration of medications. She said that medications were supposed to be given through gravity. If they are pushed, it can increase peristalsis (involuntary movements of the muscles in the digestive tract) in the stomach and cause diarrhea. Review of the facility's policy titled Enteral Medication Administration dated 1/25/13 revealed: 6. Each medication is to be prepared for separate administration. 7. Check the placement of the tube by aspiration of contents or auscultation. 8. Flush the tube with 30 ml water or according to physician order. 9. Administer one medication at time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered. 10. Once all medication has been administered, flush the tube with 30 ml water or according to physician order. 11. Do not force any medication or fluid into the tube. Allow gravity to work.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observations, interviews, and record review, the facility failed to provide food that accommodated resident's preferences for two (Resident #45 and Resident #53) of six residents reviewed for food preferences and the accommodation of resident's meal choices. The facility failed to provide Resident #45 and Resident #53 with preferred foods when they failed to provide them information about alternate meals available to them. This failure could affect the residents who are provided daily meals by the facility, by placing them at risk for not enjoying meals, and weight loss. Findings included: Resident #45: Review of Resident #45's admission record, dated 04/18/24, reflected she was a [AGE] year-old female, admitted [DATE], with diagnoses of stroke, broken femur, diabetes, Bell's palsy (a condition causing one side of the face to droop), major depressive disorder, heart failure, and dependence on renal dialysis. Review of Resident #45's quarterly MDS assessment, dated 02/28/24, reflected Resident #45 was sometimes understood by others, and was able to understand others and had severely impaired vision. Resident #45 had a BIMS of 14, indicating intact cognitive function. Resident #45 had no behaviors, and no indicators of psychosis or depression. She used a wheelchair and had one-sided impairment of her lower body. Resident #45 required supervision or touching assistance with eating, and required substantial to complete assistance of staff for most other ADLs, like dressing, bathing, and hygiene. She was dependent on staff to move her in her wheelchair. Review of Resident #45's care plans reflected care plans for dysphasia (trouble swallowing) (dated 01/05/24), nausea/diarrhea (dated 01/05/24), dialysis (dated 09/27/22, including monitoring of weights), anemia (low level of iron in the blood) (dated 01/05/24), risk of unplanned weight loss or gain with a regular renal diet (09/27/22, and noting resident and family were not compliant with diet.) Review of Resident #45's weights from January of 2024 through 04/16/24 through 04/19/24 reflected her weights to be relatively stable, with fluctuations normal for a dialysis patient. An interview and observation on 04/16/24 at 10:07 AM with Resident #45 revealed her to be fully dressed with her coat on, seated in her wheelchair, waiting for someone to take her to dialysis. She said she was blind, so she had to wait right there for them. She was friendly and talkative, and said that she liked the facility, and the staff, and had few complaints. When asked about the food, Resident #45 hesitated and said she liked some of the food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/17/24 at 4:17 PM with Resident #45 and Resident #45's family member revealed that they were not happy with the food at the facility. Resident #45's family member said they were happy with the facility, for the most part, but they fail on the food. Resident #45 said the only alternate she was able to ever get was a grilled cheese sandwich. Her family member said that a staff member used to come into the room before meals and ask Resident #45 what she wanted that day, but they stopped doing that, and the resident said that nobody ever asked her if she wanted something that was different from what was on the menu, and if she asked for something, it was always the same grilled cheese sandwich. Resident #45 and her family member said neither of them knew the kitchen normally prepared an entire second alternate menu, besides the already available menu. When Resident #45 learned that they had fish while she was out at dialysis, she said she would rather have the option of fish than almost anything else they served her, any day, but she only knew they were having it when they brought it to her. Resident #53: Review of Resident #53's Admission Record, dated 04/19/24, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included sepsis (an extreme reaction in the body to an infection), unspecified protein-calorie malnutrition, dysphagia (difficulty swallowing), aphasia following stroke (difficulty speaking after a stroke), and gastroesophageal reflux (stomach acid irritating the lining of the esophagus). Review of Resident #53's quarterly MDS assessment, dated 03/14/24, reflected she was usually able to understand others, and be understood. She had a BIMS score of six indicating severe cognitive impairment. Her Functional Status indicated she had one-sided impairment of her upper and lower body, and used a wheelchair. Resident #53 was dependent on staff for most ADLs, but was able to feed herself with only set-up/ clean-up assistance from staff. Resident #53's most recent weight taken in the past 30 days was 159 pounds, and the document reflected no significant weight loss. Review of Resident #53's weights reflected a significant weight loss (over 7.5% in a three month period) of 8.8%: Review of Resident #53's care plans reflected she had care plans for an antidepressant for depression and poor appetite (01/10/23), potential risk of malnutrition (01/05/24), regular diet (02/26/24), and significant, unplanned weight loss (04/17/24). Review of Resident #53's Order Summary, dated 04/19/24, reflected an active order from 01/04/24 for Mirtazapine 15mg, 1 tablet at bedtime as an appetite stimulant. An order was added on 04/17/24 for weekly weights one time a day every Wednesday until 05/15/24. The document reflected she was on a regular diet, regular consistency, may use a divided plate. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's dietary note, dated 03/26/24, reflected RD Significant Wt Loss Note Current weight: 159.2# BMI: 26.5 Wt change: -5.4%/-9# within 30 days Diet order: Regular diet, regular texture, regular consistency; divided plates Supplement: NA; Meds: protonix, MVI/mins, mylanta, bowel meds, mirtazapine, ondansetron, gabapentin Skin: Intact; Resident seen d/t significant wt loss of -5.4%/-9# within 30 days. Res has fair average meal intake = 50-75%/meal. Res feeds self with supervision/setup help. Res often does not like the facility's food but will eat well when family brings outside food. Res also has her own snacks at bedside such as crackers. Res denies chewing/swallowing difficulty but reports nausea after eating for the past week and sometimes excess gas. Res has also had episodes of diarrhea. Res receives anti-nausea med which temporarily resolves symptoms, but symptoms are ongoing. Res reports that appetite stimulant has helped to increase her appetite, but she doesn't like several foods. She also c/o lactose intolerance and wants to avoid all dairy. Nutritional Intervention: 1) Please note that res c/o lactose intolerance; avoid all dairy. 2) Note that resident states the following food preferences: avoid salty and spicy foods, bacon instead of sausage, toast with jelly instead of biscuit, likes tuna sandwiches but not grilled cheese or deli sandwich. 3) Add jello and/or extra dessert (no cake) with lunches and dinners x30 days, end date 4/26/24. 4) Assess if med review and/or GI consult are appropriate d/t ongoing GI symptoms (diarrhea, gas, nausea).; Goals: 1. no further significant wt change 2. No s/s dehydration 3. Skin to remain intact An interview and observation on 04/16/24 at 10:32 AM with Resident #53 revealed her to be alert, and to be able to carry on a complex conversation with the surveyor. She could not remember the date, but was able to fully answer questions about her care, and other subjects. She said that they had talked with her about her weight loss, and put her on a medication to increase her appetite, because she had, at one point, gotten to where she could barely eat at all. She felt the medication was helping, but she still had problems eating enough sometimes, because she did not like the food. She said the food was her only complaint about the facility, and she was very happy there, aside from it. She said it was way too salty, and some was too spicy, and on occasion they would bring her tuna salad, or pasta salad with tuna in it, and she liked that a lot. She said she had talked to the dietician about her likes and dislikes, and they kept sending her food she did not like, and would not eat. She said she liked maybe 3-4 meals they served regularly. An interview and observation on 04/17/24 at 12:20 PM revealed Resident #53 eating lunch in her bed. She tasted the broccoli beef dish and said it was OK, and not too salty for her. She said that she did not really like beef very much, and had not eaten it for [AGE] years before she got to the facility, but if they brought her something she could stand to eat, she would eat it. She said that on 04/16/24 she had gotten the tamales for lunch, and had scraped off all of the sauce, and that made it less salty, and she was able to eat it. She did not like beans or rice, so she did not eat those. She was not aware that they had fish as an alternate. She said she really liked fish, and would have requested it, if she had known. She said did not ask for an alternate, because she did not want a grilled cheese sandwich. An interview on 04/17/24 at 1:05 PM with DM revealed nursing was supposed to ask residents if they want the meal or the alternate meal. She said sometimes she asked residents herself, like if she knew someone did not like some of the meal for that day, or they have not been eating well. Nursing staff came to the kitchen and gave her a list of people who wanted the alternate. She said the residents knew there was an always available alternative meal . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/18/24 at 2:27 PM with the Dietician revealed she knew the dietary aides talked to the residents about preferences, but she did not know how often and was not involved in that part of the process. She said she was under the impression that the Dietary Manager was very up-to-date on what the residents wanted and were requesting, but if she was not, it could be an issue that the residents might not be getting choices to meet their preferences. She said if they do not get choices that met their preferences, they might have decreased intake of food, which could lead to weight loss. An interview on 04/18/24 at 8:59 AM- CNA F revealed she just started working at the facility on 04/17/24. She said she was a temporary worker, and nobody had told her to ask the residents what they wanted for meals before the meal. She said if someone did not like their meal, she would talk to them about getting something else from the kitchen. An interview on 04/17/24 at 1:55 PM with CNA G revealed the staff used to go around and ask the residents what they wanted for their meals, and tell them the alternate, but they did not do that anymore. She said now, when the resident gets their tray, if they do not want what is on it, they can ask for an alternate. The staff would go to the kitchen and request it. In an anonymous group interview on 04/17/24, at 2:04 PM, residents complained that they were often not told about the alternate meals, or that they were out of the alternate foods. An interview on 04/17/24 at 4:22 PM with CMA B said that they did not do rounds to ask residents what their preferences were, but if a resident asked her what was on the menu, she would go and find out and tell them. She said they took the trays to the residents, and if they did not like what was on them, they could ask staff, and they would get them something else. Review of the undated copy of the always available menu reflected the menu was formatted as three forms to a sheet, to allow resident names, room numbers, and dates to be written, and a choice of food items to be circled. It reflected Lunch deadline 9:00 AM and Supper deadline 2:00 PM. The form listed a selection of entrees and sides, and included a variety of salads, burgers, deli sandwiches, steak fingers or chicken strips, boiled egg, potato chips, French fries, buttered pasta, green beans, or corn, as well as a selection of condiments/ dressings and sandwich toppings. No policy regarding food preferences was provided during the duration of the survey.

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 04/19/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for one of five residents (Resident #57) observed for infection control. CNA A failed to perform hand hygiene while providing incontinence care to Resident # 57. This failure could place the residents at risk for infection. Findings include: Record review of Resident #57's face sheet dated 04/17/24 reflected she was [AGE] years old female. She was admitted to the facility on [DATE]. She was admitted with muscle weakness, difficult walking, hypertension (high blood pressure) history of falls and cognitive communication problem. Review of Resident #57 's care plan initiated 08/15/23 reflected Resident #57 had bladder incontinence and retention of urine. Intervention was to provide incontinent care at least every two hours and apply moisturizer after each episode. Observation on 04/17/24 at 11:34 AM revealed CNA A providing incontinent care to Resident #57. CNA A was observed completing hand hygiene and gloved before care, then she informed the resident she was providing incontinent care. CNA A positioned the resident and unfastened the brief and proceeded to clean Resident #57's front area, then positioned the resident on her side and cleaned her bottom area. Resident #57 was minimally soiled with urine and feces. After cleaning the resident CNA A did not complete hand hygiene or change gloves then she applied the clean brief, barrier cream and then fastened the brief and positioned the resident using the bed remote. With the same gloves CNA A touched the resident's clean linen and bedside table. After care CNA A completed hand hygiene and left the room with trash. In an interview on 04/17/24 at 12:02 PM with CNA A she stated she forgot to change gloves during care. CNA A stated she was expected to clean hands before and after care, but she was not required to wash hands after cleaning the resident. CNA A stated she was supposed to complete hand hygiene and change gloves during incontinent care to prevent cross contamination. She stated she had been in-serviced on infection control on 04/16/24. In an interview on 04/17/24 at 03:24 PM with the DON she stated during incontinent care the staff was to complete hand hygiene before and after care. DON also stated in between care CNA A was to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated CNA A was to complete hand hygiene during care to prevent the spread on infection. The DON stated the nursing staff had been offered the in-service on hand hygiene/infection. The inservice was reviewed and reflected CNA A had been in-serviced. Review of the facility policy undated and titled, Fundamentals of Infection Control Precautions reflected, . Hand Hygiene. (continued on next page)

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 04/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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: o When coming on duty; o When hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves. Failure to change gloves between resident contacts is an infection control hazard.