STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745051	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 out of 8 residents (Resident #1) reviewed for abuse/neglect. The facility failed to ensure Resident #1 was not neglected by not checking on Resident #1 from 2:40pm - 4:40pm on 08/26/2025. Resident #1 was found outside with a temperature of 104 degrees [F] and sent to the hospital due to being unresponsive and tachycardic (your heart is beating too fast, over 100 times a minute at rest). The temperature on 08/26/25 was a high of 97 degrees [F]. An IJ was identified on 08/28/2025 at 4:15 PM. While the IJ was removed on 08/29/2025 at 10:27 AM, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems This deficient practice could place residents at risk of injury, psychosocial harm, hospitalization and death. Findings included: Record review of Resident #1's admission record, dated 08/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: multiple sclerosis (a disease where your immune system mistakenly attacks the protective fatty covering around your nerve in the brain and spinal cord), sickle cell (a condition where red blood cells become abnormally sickle), scoliosis (an abnormal sideways curving of the spine that often looks like a C or S shape when viewed from the back), adult failure to thrive (a syndrome not a specific disease, characterized by a general decline in health, marked by weight loss, decreased appetite, poor nutrition, and increased inactivity), and unspecified lack of coordination (trouble controlling you movements, making them jerky, unsteady, and clumsy instead of smooth and precise). Record review of Resident #1's Quarterly MDS assessment, dated 06/06/2025, reflected the resident had a BIMS score of 15, which indicated cognition intact. Resident #1 was dependent in the areas of eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #1's care plan, dated 08/28/2025, reflected Resident #1 wanted to go outside and sit and move himself around by himself. This focus was not added to Resident #1's care plan until 08/28/2025. Review of Resident #1's hospital records, dated 08/26/25, reflected He was apparently left outside in his w/c. He was found to be slumped in the WC with temp of 104 [F]. Initial temp here is 100.4 degrees [F] and he has sinus tachycardia (a normal, but faster than usual, heart rhythm) in the 110s. Record review of the local weather app with outside temperatures for the local area on 08/26/2025 was a high of 97 degrees [F}. Review of Resident #1's readmission Nurses' Note, dated 08/27/25, reflected the reason for his recent hospitalization was systemic inflammatory response syndrome (An exaggerated defense response from your body to a harmful stressor. It causes severe inflammation throughout your body. This can lead to reversible or irreversible organ failure and even death). During an interview with Resident #1 on 08/28/2025 at 12:40 PM, Resident #1 stated that went outside after lunch around 1:30pm. Resident #1 stated the NA A took him outside and left him there. Resident #1 stated that he rolled himself in the sun but did not remember anything after that. Resident #1 stated it was very hot outside and he wanted to go back inside but nobody was around to take him back inside. During an interview with LVN A on 08/28/2025 at 10:25 AM, LVN A stated the NP possibly brought Resident #1 in from outside around 4:40pm, but she was not certain. LVN A stated the NP wheeled the resident to the nurse's station and asked if she could take his vitals because he wasn't responding to touch or verbal commands. LVN A stated she took Resident #1's blood pressure and pulse but did not take Resident #1's temperature. LVN A stated the facility put damp towels on Resident #1's arms, forehead, and the back of his neck to cool him down. LVN A stated she did not know how long Resident #1 was outside and stated she did not see him at 1:15pm when she went to lunch. LVN A stated she was not sure who was responsible for checking on the residents when they sat outside. LVN A stated that a negative outcome could be the resident could have heat exhaustion from sitting in the sun. During an interview with the DON on 08/28/2025 at 10:55 AM, the DON stated she was not aware of how Resident #1 got outside. The DON stated the resident was outside for about 30-45minutes per the GRC. The DON stated when she walked up Resident #1 was at the nurse station with LVN A receiving oxygen. The DON stated that Resident #1's vital were good but he was sent out per the NP. The DON stated that she was not aware that Resident #1's temperature was not taken prior to him going to the hospital. The DON stated while at the nurse station Resident #1 was slumped over with a little bit of drool coming from his

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure each resident received adequate supervision for 1 of 8 resident (Resident #1) reviewed for supervision. The facility failed to ensure Resident #1 had adequate supervision or was checked on for over two hours as he was found outside on 08/26/25 with a temperature of 104 degrees [F] and sent to the hospital due to being unresponsive and tachycardic (your heart is beating too fast, over 100 times a minute at rest). The temperature on 08/26/25 was a high of 97 degrees [F]. An IJ was identified on 08/28/2025 at 4:15 PM. While the IJ was removed on 08/29/2025 at 10:27 AM, the facility remained out of compliance at a level of no actual harm at a scope of isolated with a potential for more than minimal harm, that was not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems This deficient practice placed residents at risk for falls, injuries, dehydration, hospitalization, and death. Findings included: Record review of Resident #1's admission record, dated 08/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: multiple sclerosis (a disease where your immune system mistakenly attacks the protective fatty covering around your nerve in the brain and spinal cord), sickle cell (a condition where red blood cells become abnormally sickle), scoliosis (an abnormal sideways curving of the spine that often looks like a C or S shape when viewed from the back), adult failure to thrive (a syndrome not a specific disease, characterized by a general decline in health, marked by weight loss, decreased appetite, poor nutrition, and increased inactivity), and unspecified lack of coordination (trouble controlling you movements, making them jerky, unsteady, and clumsy instead of smooth and precise). Record review of Resident #1's Quarterly MDS assessment, dated 06/06/2025, reflected the resident had a BIMS score of 15, which indicated cognitive intact. Resident #1 was dependent in the areas of eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #1's care plan, dated 08/28/2025, reflected Resident #1 want to go outside and sit and move himself around by himself. This focus was not added to Resident #1's care plan until 08/28/2025. Review of Resident #1's hospital records, dated 08/26/25, reflected He was apparently left outside in his w/c. He was found to be slumped in the WC with temp of 104 [F]. Initial temp here is 100.4 degrees [F] and he has sinus tachycardia (a normal, but faster than usual, heart rhythm) in the 110s. Record review of the local weather app with outside temperatures for the local area on 08/26/2025 was a high of 97 degrees [F}. Review of Resident #1's readmission Nurses' Note, dated 08/27/25, reflected the reason for his recent hospitalization was systemic inflammatory response syndrome (An exaggerated defense response from your body to a harmful stressor. It causes severe inflammation throughout your body. This can lead to reversible or irreversible organ failure and even death). During an interview with the Resident #1 on 08/28/2025 at 12:40 PM, Resident #1 stated that went outside after lunch around 1:30pm. Resident #1 stated that NA A took him outside and left him there. Resident #1 stated that he rolled himself in the but doesn't remember anything after that. Resident #1 stated it was very hot outside and he wanted to go back inside but nobody was around to take him back inside. During an interview with the LVN A on 08/28/2025 at 10:25 AM, the LVN A stated the NP possibly brought Resident #1 in from outside around 4:40pm, but she was not certain. LVN A stated that the NP wheeled the resident to the nurse's station and asked if she could take his vitals because he wasn't responding to touch or verbal commands. LVN A stated she took Resident #1 blood pressure, pulse, but did not take Resident #1 temperature. LVN A stated the facility put damp towels on Resident #1's arms, forehead, and the back of the neck to cool him down. LVN stated she did not know how long Resident #1 was outside but stated she did not see him at 1:15pm when she went to lunch. LVN stated she was no sure who was responsible for checking on the residents when they sat outside. LVN A stated that a negative outcome could be resident could have heat exhaustion from setting in the sun. During an interview with the DON on 08/28/2025 at 10:55 AM, the DON stated she was not aware of how Resident #1 got outside. The DON stated that resident was outside for about 30-45minutes per the GRC. The DON stated when she walked up the Resident #1 was at the nurse station with LVN A receiving oxygen. The DON stated that Resident #1 vital were good but was sent out per the NP. The DON stated that she was not aware that Resident #1 temperature was not taken prior to him going to the hospital. The DON stated while at the nurse station Resident #1 was slumped over with a little bit of drool coming from his mouth. The DON stated Resident #1 was not verbally saying anything at that time. The DON stated she was told that

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interview, and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 3 (08/26/2025, 08/27/2025, 08/28/2025) of 4 days reviewed for nurse staffing posting.The facility failed to post the daily staffing information in a prominent place on 08/26/2025, 08/27/2025, and 08/28/2025. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings:During an observation on 08/28/2025 at 9:06 am, revealed the nursing staffing information posted outside out the DON's office was dated 08/25/2025.During an interview with the DON on 08/29/2025 at 2:30 PM, the DON stated she was responsible for posting the nursing staffing information. The DON stated she had not posted the nursing staff information since 08/25/2025. The DON stated the residents would not be affected by the nursing information not being posted. The DON stated the nursing staffing show transparency of the number of staff present for each shift. During an interview with the ADM on 08/29/2025 at 2:45 PM, the ADM stated the nursing staffing information should be posted daily. The ADM it was the DON's or the ADON's responsibility to ensure it was posted daily. The ADM stated the purpose of posting the nursing staffing information was to show that the facility had adequate staffing. The ADM stated the residents would not suffer any adverse effects if the nursing staff information was not posted. The ADM stated the facility did not have a policy regarding the posting of the nursing staff information.