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	12/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent development or promote wound healing for one (Resident #1) of three residents reviewed for pressure ulcers. The facility failed to provide treatments on from 10/03/2025 thru 10/09/2025 to a skin tear on Resident #1's shin on the right lower leg. This failure could place residents at risk for worsening skin concerns leading to discomfort, pain, and potential infections. Findings included: Review of Resident #1's face sheet, dated 09/16/2025, reflected a [AGE] year-old male who was admitted on [DATE] with diagnoses which included type 2 diabetes (a chronic condition where the body either does not use insulin properly or does not produce enough insulin, leading to high blood sugar levels), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (memory loss, difficulty with communication, confusion and problems with making decisions the specific underlying cause cannot be identified. The person does not have behaviors with dementia), heart failure- unspecified (a general decline in the heart's ability to pump blood effectively without specifying the underlying cause), unspecified protein -calorie malnutrition (a condition where a person does not consume enough protein and calories to meet their nutritional needs). Review of Resident #1's admission MDS Assessment, dated 09/19/2025, reflected Resident #1 had a BIMS score of 13 which indicated his cognition was intact. Resident #1 was dependent on staff for putting on/taking off footwear, transfers, and toileting hygiene. He required substantial/maximal assistance- (helper does more than half the effort) with showers and lower body dressing. Resident #1 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. Resident #1 had was at risk for developing pressure ulcers/injuries. He had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Resident #1 had a diabetic foot ulcer. Review of Resident #1's Comprehensive Care Plan, revised on 10/16/2025, reflected Resident #1 had diabetes mellitus. Intervention: Check all body for breaks in skin and treat promptly as ordered by doctor. Resident #1 had a skin tear, laceration or abrasion to right leg. Intervention: Perform any wound care as ordered. Monitor and treat pain as indicated. Resident #1 was at risk for falls related to chronic ulcer to right foot. Resident #1 was admitted to facility with deep tissue injury (a type of pressure ulcer where damage occurs to the underlying skin and soft tissue) to right first toe and right heel and diabetes mellitus to right second and third toe (all have been healed). Record review of Resident #1's physician order, dated 09/30/2025, reflected skin tear right shin: cleanse with NS, pat dry with gauze. Apply xeroform and cover with dry dressing. Resident #1's wound treatment was one time a day for wound healing on Monday, Wednesday and Friday every night between 6 PM to 6 AM. Record review of Resident#1's Physician Order, dated 10/09/2025, reflected skin tear right shin: cleanse with NS, pat dry with gauze. Apply calcium alginate and cover with dry dressing, one time a day every Monday, Wednesday, and Friday for wound healing. Record review of Resident #1's Weekly Non-Ulcer Wound Assessment, dated 09/30/2025, reflected Resident #1 had a wound on right shin (lower leg). The type of wound was skin tear. The measurement of the skin tear was length- 2.5 cm, width 1.0 cm, depth 0.1 cm. The skin tear exudate (a fluid, rich in cells and proteins, that leaks from blood vessels into nearby tissues due to inflammation) amount was moderate, color was yellow, and exudate character was clear. There was no odor. Record review of Resident #1's Weekly Non-Ulcer Wound Assessment, dated 10/09/2025, reflected Resident #1 had a wound on right shin (lower leg). The type of wound was skin tear. The measurement of the skin tear was length- 3.0 cm, width 1.0 cm, depth 0.1 cm. The skin tear exudate amount was moderate, exudate color was yellow, and exudate character was clear. Resident #1's skin tear did not have any odor. Record review of Resident #1's treatment record reflected Resident #1 received treatment to his right leg on 10/02/2025, 10/03/2025, 10/06/2025,10/08/2025 and 10/10/2025. Interview on 10/28/2025 at 8:35 AM Treatment Nurse LVN A stated the treatment records was not correct. She stated LVN B documented she completed treatment to Resident #1's right shin on the following dates: 10/06/2025, 10/08/2025, and 10/10/2025 on the treatment administration record by mistake and LVN B did not provide any type of treatment on these dates to Resident #1 right shin. Treatment Nurse LVN A stated Resident #1 did not receive treatment to his right shin from 10/02/2025 until 10/10/2025. She stated she entered the order for Resident #1 on 09/30/2025 and it was the wrong order. Treatment Nurse LVN A stated she made a mistake and entered for Resident #1 to receive treatment to his shin Monday, Wednesday and Friday at night. She stated the order was for him to receive

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keysfor 1 of 3 medication carts (Medication Cart #1) reviewed for medication storage. The facility failed to prevent Medication Cart #1 was locked and medications were secure and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the counter medications. Findings included: Observation on 10/28/2025 at 2:37 AM revealed an unlocked medication cart #1 in front of one of one nurses' station. RN C was sitting behind the nurse's station. Interview on 10/28/2025 at 2:40 AM RN C stated she did not realize the medication cart was unlocked. She stated all medication carts were to be locked except when a nurse was obtaining medications from the cart. RN C stated if a resident did ingest medications the resident was allergic to there was a possibility the resident may have a reaction and possibly die. She stated a resident also had a potential of overdosing on medications or give the medications to another resident. RN C stated she had been in-serviced on locking medication carts; however, she did not recall the date of this in-service. Observation on 10/28/2025 at 3:58 AM revealed an unlocked medication cart #1 in front one of one nurses' station. There was not a nurse around the medication cart or around the nurse's station. RN C walked from 300 hall toward the nurses' station approximately 10 minutes after the medication cart was found unlocked by the surveyor. Interview on 10/28/2025 at 4:15AM RN C stated she walked away from the cart to assist a resident down the hall. She stated she thought she locked the medication cart. RN C stated this is second time today I forgot to lock the medication cart. She stated she did not have an explanation of why she did not lock the medication cart. She stated a resident, staff or visitor had access to the medications and anyone could have taken the medications, and no one would have known a resident, staff or visitor had taken the medication. She stated if a resident was allergic to the medication they may need to be hospitalized and possibly could die from an overdose. She stated she did not recall the date she was in-service on locking medication cart. RN C stated the ADON informed her earlier she would be in-serviced today (10/28/2025) on locking medication cart. Interview on 10/28/2025 at 4:35 AM the ADON stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. ADON stated she was starting an in-service today and she did not recall the last time the facility had in-service on locking medication carts with the nurses and medication aides. She stated it was the nurse's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. Record review of the Facilities Policy on Medication Storage in the Facility, not dated, reflected Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, or staff members lawfully authorized to administer medications.