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	12/22/2025

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 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)

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 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 that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #2) of 3 residents. The facility failed, on 12/08/25, to ensure two staff members assisted Resident #2 off the toilet and onto her wheelchair. Resident #2 fell and hit her knee on the toilet paper dispenser when CNA E transferred her off the toilet alone. Resident complained of pain. On 12/10/25 an x-ray revealed Resident #2 had a broken femur, was sent to the hospital and had surgery. An Immediate Jeopardy (IJ) was identified on 12/21/2025. The IJ template was provided to the facility on [DATE] at 2:07 pm. While the IJ was removed on 12/22/25 at 7:54 pm, the facility remained out of compliance at a scope of isolated and severity level of no actual harm. Findings included: Record review of Resident #2's face sheet, dated 12/21/25, revealed a ninety-three-year-old woman who was admitted to the facility on [DATE] and readmitted on [DATE]. Her admitting diagnoses included fracture of left femur (a severe break in the thigh bone, causing intense pain, swelling, deformity, and inability to bear weight), peripheral vascular disease (a circulatory problem where narrowed blood vessels outside the heart and brain reduce blood flow to limbs and organs, most commonly the legs, often due to plaque buildup (atherosclerosis), and congestive heart failure (a chronic condition where the heart muscle weakens or stiffens, preventing it from pumping enough blood to meet the body's needs, causing blood and fluid to back up, often into the lungs, legs, and feet).Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 11/23/25 revealed a score of 15 indicating no cognitive issues and Section GG - Functional Abilities - toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement managing an ostomy, include wiping the opening but not managing equipment dependent - helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity.Record review of Resident #2's care plan revealed a focus dated 11/09/25 that indicated Resident #2 had ADL self-care performance deficit with interventions:Toilet use: required staff x2 for assistance dated 11/09/25 and the resident required mechanical aid ([mechanical lift] x2 assist) for transfers dated 07/30/25 and Resident #2 required mechanical aid ([mechanical lift] x2 assist) for transfers dated 07/30/25.Review of the facility's self-report to HHS dated 12/16/25 reflected an incident occurred on 12/08/25 in Resident #2's bathroom and the facility first learned of the incident on 12/10/25. Resident #2's RP reported that [Resident #2's] injury was caused by 1 person assisting her to the bathroom instead of two. Record review of a statement dated 12/08/25 by the ADON reflected, I was notified that [Resident #2] was on the floor by [CNA D] when I entered the restroom I observed the [CNA E] assisting [Resident #2] to the floor. The CNA stated that the [Resident #2] believed she could stand up to get in the chair on her own so she stood up and her [left] knee gave out so she lowered her to the floor before the other CNA could answer the emergency light. I notified the nurse taking care of the resident of the fall. [Resident #2] was assessed and placed back into wheelchair. No apparent injuries were noted at that time.Record review of a statement dated 12/08/25 by CNA E reflected, on Dec. 8th [2025] I assisted the resident onto the toilet with another CNA and waited for the emergency light to come on. The other CNA went to go help another resident in the meantime and when the bathroom light came on, I went inside and the resident was ready to get in the wheelchair, so she stood up before the other CNA came back and then her leg gave out and I was forced to lower the resident to the floor. I them immediately went to get help did notify hall 4 nurse. Record review of an interview taken by the Administrator from Resident #2 reflected, On 12/16, I spoke with the resident [Resident #2], about the incident that occurred on 12/8 [2025], the resident raised her two fingers and stated there should have been two people. Record review of an interview taken by the Administrator from Resident #2's RP reflected, On 12/16 [2025], I spoke with the [RP] who mentioned that [Resident #2] was assisted out from the toilet by one staff member instead of two. I stated that I was informed that she was attempting to get out of the commode and her knee gave out, so the CNA assisted her to the floor. [RP] mentioned that [Resident #2] would not attempt to get up without assistance. The [RP] stated that the nurse mentioned exactly what I stated, but there is no way [Resident #2] will attempt to get up without assistance. I told the family that I will investigate. Review of Resident #2's progress note dated 12/15/25 by the DON reflected Resident #2 had a witnessed fall resulting

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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 provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of two residents reviewed for medication administration, in that: The facility failed to ensure they administered Resident #1 a one-time order, dated 12/10/25, of 500 ml of Sodium Chloride 0.9%. Resident #1 instead received approximately 900 ml of Sodium Chloride 0.9%. Resident #1 was sent to the hospital for SOB, and returned the same day with a diagnosis of pneumonia, no fluid overload. The failure placed residents at risk for fluid overload, shortness of breath, blood pressure issues, physical injury to organ failure. Findings included: Record review of Resident #1's face sheet, dated 12/18/25, revealed a seventy-six-year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her admitting diagnoses included acute combined systolic (congestive) and diastolic (congestive) heart failure (the heart struggles to both contract forcefully and relax properly, leading to fluid backup (congestion) in the lungs and body, causing severe symptoms like shortness of breath and swelling), chronic obstructive pulmonary disease (a progressive lung condition making it hard to breathe, characterized by inflamed airways and damaged air sacs (emphysema/bronchitis) leading to persistent cough, wheezing, and shortness of breath), and morbid (severe) obesity due to excess calories (a serious chronic condition defined by a BMI (a measure of body fat based on height and weight) of 40+ or 35+ with severe health issues, often stemming from consistently consuming more calories than the body burns, leading to excess fat storage). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/02/25 revealed a score of 14 indicating no cognitive issues. Record review of Resident #1's care plan revealed a focus dated 12/11/25 that Resident #1 had congestive heart failure and was at risk for fluid volume overload with an intervention dated 01/03/25 to report to the charge nurse any new or increased swelling, breathing problems, change in skin color, or increased difficulty performing tasks. Record review of Resident #1's order dated 12/10/25 reflected Sodium Chloride Solution 0.9% use 500 ml intravenously one time only for dehydration for 1 day; run at 75ml/hour, reassess at 250ml and 500ml. Record review of Resident #1's nurses progress note by the DON dated 12/11/25 reflected, The resident received the wrong dose of IV fluid. Record review of Resident #1's nurses progress note by RN B dated 12/11/25 reflected, [Resident #1] was transferred to a hospital on [DATE] 12:00 AM related to SOB, O2 sat 85% while pt is on 4L o2 [sic]. Record review of Resident #1's hospital records dated 12/11/25 reflected Resident #1's chief complaint was SOB. The hospital visit diagnoses was a cough and pneumonia. Review of the Provider Investigation Report dated 11/11/25 reflected, The nurse administered 900 ml of sodium chloride 0.9% instead of 500 ml. Resident [#1] was assessed and transferred to the ER. The nurse received an order to administered [sic] 500 ml sodium chloride 0.9% to the resident [#1] for dehydration. The nurse hung a 1000 ML bag. According to the nurse, he reported to the incoming nurse who was assigned to another Hall about the order and treatment plan, since his relieve [sic] was running late. The nurse assigned to the resident stated she was not informed, and did not read the order. During her last round, she noted 450-550 ml and was instructed by the incoming nurse to continue the infusion. Incoming nurse denied being given such direction. He went to the room and discontinued the IV. Around 8:01 am on 12/11 [2025] the resident complained of shortness of breath. The provider was notified and order [sic] oxygen therapy. Resident symptoms didn't improve and was transferred to the ER. The resident had a diagnosis of pneumonia. Record review of a statement by LVN A undated reflected, During my shift on 12/10/25, I arrived to the facility for my NOC shift at 1830. There was on the NOC nurse for 300/400. During my round, upon assessment, it was observed at 0650 that resident had approximately 800 - 700 ml of Normal Saline in the bag. During my mid early morning rounds, I went to get the U/A that was ordered and also to administer the resident's Synthroid, there still was alot of fluid left in the bag. I had to take care of a resident on 200 for quite some time. When I made my last rounds, the resident had approx. 450-550 ml remained [sic] at around 0551. The dayshift RN advised meto [sic] allow the infusion to continue until he was able to consult with the Nurse Practitioner (NP) citing concern regarding the resident Systolic BP [the top number in a blood pressure reading, measuring the pressure in your arteries when your heart beats and pushes blood out], which was noted to be I the [sic] high 90s. Resident was stable @ 0600. Report given to [RN B]. This nurse left the facility @ or around 0647. Record review of a statement by RN B dated 12/11/25