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	05/08/2026

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for two of eight (Resident #1 and Resident #2) residents reviewed for quality of care. 1. The facility failed to provide urostomy (a surgical procedure that creates an alternate pathway for urine to leave the body though an artificial opening on the abdomen) bags for Resident #1.2. The facility failed to provide tracheostomy (a surgical hole created through the neck to the trachea to assist with breathing) inner cannulas (a removable tube within a tracheostomy that helps keep the airway clear of mucus and debris) and Enemeez (a docusate sodium mini enema used to treat constipation) for Resident #2.These failures placed residents at risk of injury, infection, not receiving adequate care and services, and decreased quality of life.Findings include:Review of Resident #1's admission record, dated 05/06/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: quadriplegia (a condition that causes paralysis in all four limbs) and other artificial openings of urinary tract status. Review of Resident #1's quarterly MDS assessment, dated 04/24/2026, reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #1's physician order summary, dated 05/06/2026, reflected Urostomy bag - change PRN with a start date of 01/08/2025. Review of Resident #1's care plan, dated 08/06/2025, reflected The resident has an urostomy with interventions that included .Perform ostomy (a surgical hole to create an artificial opening) care as ordered.change urostomy bag & ring prn.During an interview and observation on 05/06/2026 at 2:06 PM, Resident #1 stated he had his family purchase urostomy bags because the bags provided by the facility were not the correct bags. Resident #1 stated he spoke with the CSC and the bags she was able to obtain were colostomy (an artificial opening on the abdomen to divert waste from the digestive system) bags and not urostomy bags. He stated the colostomy bags did not provide a drain with extension to reach his foley catheter (a collection device for urine) bag. He stated he had provided his FM with $60 every month for 2 months to purchase the urostomy bags. Observation of the bags provided by the facility revealed a box of colostomy bags. Review of Resident #2's admission record, dated 05/06/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] and discharged to the hospital on [DATE] with diagnoses that included: quadriplegia (a condition that causes paralysis in all four limbs), neurogenic bowel (a condition in which nerve damage disrupts normal bowel function leading to constipation, fecal incontinence, or difficulty controlling bowel movements), neuromuscular dysfunction of bladder (a condition in which the normal communication between the bladder and the nervous system is disrupted causing bladder control issues), dysphagia (difficulty swallowing), and tracheostomy status (a surgically created opening in the trachea used to assist with breathing). Review of Resident #2's comprehensive MDS assessment, dated 04/05/2026, reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #2's physician order summary dated 05/06/2026 reflected the following orders: Change inner Cannula size 4 Shiley (type of inner cannula) every shift related to TRACHEOSTOMY STATUS with a start date of 04/13/2026, Enemeez Mini Rectal Enema 283 MG/5ML Insert 1 insert rectally one time a day related to NEUROGENIC BOWEL with a start date of 04/04/2026, DSS Oral Capsule 100 (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 - Some	MG Give 1 capsule by mouth three times a day related to NEUROGENIC BOWEL with a start date of 04/04/2026, and Senna Oral Tablet Give 8.6 mg by mouth three times a day for Constipation take before meals. Take before lunch specifically with a start date 04/04/2026. Resident #2 had an order as follows: 1. Position on left side 2. Inert [sp?] lubricated loved [sp?] finger into the rectum, if you feel hard stool, gently remove it 3. Insert suppository, high into rectum beyond external internal sphincter 4. Push the suppository against the side of the rectal wall. 5. After 15 minutes perform digital stimulation. Insert finger into rectum, slightly stretch the anus. Move the finger in a circular motion around the rectal wall. Continue for 1 minute. 6. After 15 minutes if there is no results repeat x2 at bedtime related to NEUROGENIC BOWEL for 2 days with a start date of 04/05/2026 and end date of 04/07/2026. Review of Resident #2's care plan, dated 04/12/2026, reflected The resident has Tracheostomy r/t with interventions that included TUBE OUT PROCEDURES: Keep extra trach tube at bedside. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Notify EMS IMMEDIATELY.Review of Resident #2's care plan, dated 04/12/2026, reflected The resident has hemiplegia/Hemiparesis (paralysis or weakness on one side of the body) r/t with interventions that included Give medications as ordered. Monitor/document for side effects and effectiveness.During an interview on 05/06/2026 at 11:23 AM, FM A stated they had to purchase the inner cannulas and Enemeez for Resident #2 because the facility did not have the needed supplies. She stated Enemeez, quantity of 35, was purchased on 04/16/2026 and inner cannulas, quantity of 10, were purchased on 04/17/2026. FM A stated there was a care plan meeting with the ADM and the DON on 04/13/2026 related to the care needed for Resident #2 and the necessary supplies. She stated the supplies were not provided after that meeting which prompted the family to purchase and provide the facility with the supplies.Record review of a facility provided invoice, dated 04/07/2026, reflected an order for Mini-Enemas quantity of 5 purchased. Record review of a facility provided invoice, dated 04/17/2026, reflected an order for CANNULA, INNER, SHILEY, SIZE 4. quantity of 1 pk purchased.During an interview on 05/07/2026 at 01:12 PM, the NP stated Resident #2 had a re-usable inner cannula that just needed to be cleaned and not changed until 04/13/2026. She stated she believed the facility was providing care by cleaning the inner cannula from 04/03/2026 until 04/13/2026 when the order was added to change the inner cannula. She stated the facility was using oral docusate sodium, senna, and the digital stimulation program in place of using the Enemeez, and the combination of the 3 was equivalent. The NP stated a colostomy bag is not the same as a urostomy bag. She stated the bag needed a connector for the urine to drain from the bag and into the foley catheter bag. The NP stated if a colostomy bag was used in place of a urostomy bag then the bag would probably leak urine. During a phone interview on 05/07/2026 at 04:16 PM, LVN A stated she worked with Resident #2 on 04/18/2026 and 04/19/2026. She stated on 04/18/2026, FM A provided inner cannulas for Resident #2, and the inner cannula was changed that day. She stated she was not scheduled to administer the Enemeez and was unsure if it was available. During an interview on 05/08/2026 at 09:42 AM, the CSC stated she had been trained in ordering needed supplies for the facility when she accepted the position. She stated, if supplies were not available to be ordered through their supplier, then she could go to the store or order it on-line. She stated Resident #1 had his family purchase his own urostomy bags because he was particular about the type that was ordered and he preferred a different bag than the facility provided. She stated she notified the ADM and DON about Resident #1's family purchasing his urostomy bags. She stated she did not know the difference between urostomy and colostomy bags. The CSC stated was not informed about the need for the inner cannula until 04/14/2026 and she ordered them that day. She stated she did not have any inner cannulas in the facility prior to that order. The CSC stated she ordered the Enemeez on 04/07/2026 from a local store. After reviewing the invoice, the CSC stated she purchased a quantity of 5 that would have lasted 5 days. She stated she was not told to order any more after that. During an interview on 05/08/2026 at 1:43 PM, the DON stated she was notified that Resident #1's family was purchasing his urostomy bags recently by (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1. She stated she had changed Resident #1's urostomy bag recently and he indicated he wanted to use the urostomy bags that his family had purchased. During the interview a picture of the bag purchased by the facility was provided to the DON. She stated that the picture reflected a colostomy bag and not a urostomy bag. She stated a colostomy bag could not be used in place of a urostomy bag because the bag needs a drain for the tube to connect to the foley drainage bag. The DON stated the facility was responsible for purchasing the correct urostomy bags for Resident #1. The DON stated that when the facility received report for Resident #2, they were told that Resident #2 was in the process of trying to discontinue her tracheostomy and they were told that no care was needed for the tracheostomy, including changing the inner cannula. She stated the facility did not have tracheostomy inner cannulas in the facility when Resident #2 was admitted . She stated that it is a standard of care to keep an extra inner cannula at the bedside in case of dislodgement, but thought that if it did become dislodged, they had the supplies to clean the inner cannula to be able to reinsert it. She stated not having extra inner cannulas in the facility could cause breathing difficulties if the tracheostomy were to become dislodged. The DON stated she was not aware if Resident #2's family had purchased inner cannulas and brought them into the facility. She stated the facility ordered inner cannulas after a discussion with the family of Resident #2. The DON stated it was the responsibility of the facility to provide inner cannulas for Resident #2. The DON stated she assumed the Enemeez were not started upon admission to the facility because they were difficult to locate in store and had to be ordered online. After reviewing the invoice for the Enemeez purchased by the facility she stated the facility received a quantity of 5 on 4/7/2026 that should have lasted Resident #2 for 5 days. She stated she was unsure if any additional Enemeez were purchased for Resident #2 after the initial purchase. The DON stated the facility was responsible for providing Enemeez for Resident #2. She stated she expected the CSC to notify her if there are any difficulties in obtaining the needed supplies for residents. The DON stated if the residents had to purchase their own needed medical supplies, then it could affect the residents financially. During an interview on 05/08/2026 at 04:08 PM, the ADM stated she was not notified that the facility had ordered colostomy bags for Resident #1 instead of the urostomy bags. She stated it was not her expectation to use colostomy bags in place of urostomy bags. The ADM stated she would expect to be notified by the CSC about difficulty in locating supplies. She stated she did not think that the CSC knew the difference between colostomy and urostomy bags. The ADM stated she was not aware that Resident #1's family was purchasing his urostomy bags. She stated the facility was responsible for providing the urostomy bags for Resident #1 and she had intentions on reimbursing Resident #1's family for the urostomy bags they had purchased. The ADM stated that when Resident #2 was admitted to the facility, the facility received in report that Resident #2 had a tracheostomy but Resident #2 was being weaned off the tracheostomy and did not require any care for it. The ADM stated there was not an order from the previous facility related to order to change the inner cannula. She stated it was not until the family raised a concern about changing the inner cannula, that the facility realized it needed to be changed and the facility ordered the supplies. She was unsure of the date she spoke with the family related to their concerns. The ADM stated the Enemeez was not in stock in the facility when Resident #2 was admitted , but they ordered it. After reviewing the invoice for Enemeez, the ADM stated they ordered a quantity of 5 Enemeez, and that quantity would have lasted Resident #2 for 5 days. She stated it was the facility's responsibility to provide the inner cannulas and Enemeez for Resident #2. She stated Resident #2's family brought in a box of Enemeez for Resident #2 because they did not want them to go to waste. The ADM stated she was unsure how the missing supplies could affect the residents, but to her knowledge there were no adverse effects to the residents due to the lack of supplies. Review of the, undated, facility admission agreement reflected .MEDICAL SUPPLIES AND EQUIPMENT1. Medical accessories and equipment ordered by Resident's physician and required to provide treatment ordered such as: cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids and equipment, wheelchairs, crutches, canes, walkers, trapeze bars, mattresses and hospital type beds, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enteral pumps and oxygen equipment are paid by Medicaid for Medicaid residents.MEDICARE PART A SKILLED STAY COVERED SERVICES & CHARGES.These charges are included, you will not be billed for the following services:Room and BoardRoutine Nursing CareRoutine Supplies and EquipmentThese charges are included, you will not be billed for the following services, with appropriate physician orders:PharmacyRadiologySpeech PathologyChargeable Medical SuppliesIV TherapyLaboratoryOccupational TherapyPhysical Therapy.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide care, consistent with professional standards of practice, to heal pressure injuries for one resident (Resident #2) out of four residents reviewed for pressure injuries.The facility failed to assess the wound to Resident #2's sacrum (the triangular area at the base of the spine fused between the hips) and acquire orders upon admission on [DATE] until 04/08/2026. This failure could place residents at risk of worsening wounds, infections and pain. Findings included:Review of Resident #2's admission record, dated 05/06/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] and discharged to the hospital on [DATE] with diagnoses that included: quadriplegia (a condition that causes paralysis in all four limbs), paralytic syndrome (a medical condition characterized by partial or complete loss of muscle function due to nerve or neurological impairment), and other reduce mobility. Review of Resident #2's comprehensive admission MDS, dated [DATE], reflected a BIMS score of 15 indicating no cognitive impairment. Section M - Skin Conditions reflected Resident #2 had a pressure ulcer/injury that was classified as Unstageable - Deep tissue injury. Review of Resident #2's order summary, dated 05/06/2026, reflected clean unstageable wound to sacrum with normal saline, pack with moistened gauzed [sp?], apply skin prep to periwound (area directly around the wound), cover with bordered foam. Two times a day for unstageable wound to sacrum with start date of 04/08/2026 and was discontinued without an end date; Stage 4 (a wound that extends through all layers of the skin and fat tissue reaching deeper structures such as muscle, tendon, ligament, cartilage, or bone) sacrum: Clean with NS, pack with moistened (NS) gauzed [sp?], apply skin prep to peri wound, cover with dry dressing. Two times a day for unstageable wound to sacrum with start date of 04/12/2026 and Doxycycline Hyclate Oral Tablet 100 MG Give 1 tablet by mouth two times a day for wound infection for 10 days with a start date of 04/12/2026. Review of Resident #2's care plan, dated 04/12/2026, reflected The resident has a pressure ulcer or potential for pressure ulcer development: Stage 4 Sacrum with interventions that included Follow facility policies/protocols for the prevention/treatment of skin breakdown.Review of Resident #2's initial progress note, dated 04/04/2026 reflected, Unstageable (a pressure ulcer whose depth and severity cannot be determined because the wound bed is completely covered by dead tissue) to sacrum.Review of Resident #2's the wound care provider note, dated 04/08/2026, reflected a stage 4 pressure wound to the sacrum that was 5 x 6 x 1.1 cm with treatment plan of Primary dressing Gauze sponge sterile apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: NS mosit [sp?] to dry daily changes. Secondary Dressing Gauze island w/ bdr apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. During an interview on 05/06/2026 at 11:23 AM with Resident #2 and FM A, they stated they were concerned about worsening condition of Resident #2's wound due to staff not providing care to the wound. During an interview on 05/07/2026 at 10:53 AM, the wound care doctor stated he had evaluated and treated Resident #2's wound 2 times while at the facility. He stated even though there were no orders for wound care from 04/04/2026 until 04/08/2026, Resident #2's wound had no change in condition since she left the hospital. The wound care doctor stated Resident #2's wound had necrosis (premature cell death) to the wound bed, and the wound was getting better by getting rid of the necrosis. He stated he was disappointed at the hospital in which Resident #2 resided prior to admission to the facility because Resident #2 should not have been discharged from the hospital with the wound in the condition it was in with all of the necrosis.During an interview on 05/07/2026 at 1:12 PM, the NP stated the smell to Resident #2's wound had changed on 04/12/2026 and she started doxycycline until the wound care doctor could assess the wound. She stated Resident #2's hospitalization was not related to no wound care provided from 04/03/2026-04/08/2026 because too much time had passed prior to her hospitalization on 04/19/2026 for it to be related. She stated Resident #2's hospitalization was inevitable due to her comorbidities and history of previous hospitalizations. During an interview on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/07/2026 at 3:24 PM, the treatment LVN stated his first day as the treatment nurse was on 05/06/2026, but he was one of the charge nurses that provided care to Resident #2 prior to her hospitalization on 04/19/2026. He stated he worked with Resident #2 on 04/06/2026 and he did a dressing change by cleaning the wound and applying a foam bordered dressing, even though there was not an order, because the dressing was soiled. He stated prior to her hospitalization on 04/19/2026, Resident #2's wound was starting to improve but it did develop an odor. During an interview on 05/08/2026 at 01:43 PM, the DON stated the admitting nurse was responsible for obtaining wound care orders, but she was unsure who the admitting nurse was. She stated she was responsible for ensuring orders were obtained on the next business day after any admission. She stated she was unsure why no orders were obtained upon Resident #2's admission to the facility. The DON stated if a resident were admitted with a wound and no orders were obtained to treat the wound, then the resident would be at risk of infection. During an interview on 05/08/2026 at 3:25 PM, LVN B stated she worked with Resident #2 on 04/04/2026, 04/05/2026, 04/08/2026, 04/09/2026, 04/13/2026, 04/14/2026, and 04/17/2026. She stated on 04/04/2026 and 04/05/2026 she performed a wet-to-dry dressing because the dressing in place was soiled. LVN B stated she documented Resident #2 had an unstageable wound to her sacrum, but it was an oversight to not document the wound care provided. She stated she did not contact the on-call provider for orders related to wound care during that time. LVN B stated Resident #2's wound had some changes in color to the tissue and a consultation with the wound care provider occurred for an evaluation of the wound. She stated, to her knowledge, Resident #2 had no adverse effects due to the lack of orders for wound care from 04/03/2026 until 04/08/2026. During an interview on 05/08/2026 at 03:49 PM, LVN C stated she worked with Resident #2 on 04/04/2026, 04/05/2026, 04/07/2026, 04/08/2026, 04/14/2026, 04/16/2026, 04/17/2026, and 04/18/2026. She stated on 04/04/2026, 04/05/2026, and 04/07/2026 she observed the dressing to Resident #2's wound but did not touch the dressing because there was not an order to change the dressing. She stated it was the responsibility of the day shift nurse to obtain orders for wound care and she worked night shifts. LVN B stated the standard of care for nursing would be to have an order to monitor and care for each wound and not having an order put the resident at risk of infection. During an interview on 05/08/2026 at 04:08 PM, the ADM stated she was informed Resident #2 had a wound upon admission on [DATE]. She expected the admitting nurse to initiate standing orders for wound care that included monitoring of the wound, dressing changes and a wound care provider consultation. The ADM stated the wound care provider did an initial evaluation on Resident #2's wound on 04/08/2026 and the order for wound care was initiated at that time per direction of the wound care doctor. She stated she wanted to believe the nursing staff provided wound care from 04/03/2026 until 04/08/2026, but she was unsure if the nursing staff documented the wound care. The ADM stated if a resident went 5 days without wound care it could affect a resident because the wound could become uncomfortable or the resident would not feel good about the care provided to the wound. Review of facility policy titled Pressure Ulcer: Prevention, Assessment and Treatment Protocol, dated 05/05/2025, reflected Procedure:1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection.3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will:1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document Notification.6. Nursing Action/Rationale: . 10. Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage as listed in this procedure. Notify physician; obtain an order and monitor site. Sign off on treatment sheet any treatment completed.