

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Five Points Nursing & Rehabilitation of College St		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible and failed to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 1 of 7 residents (Resident #1) reviewed for resident rights. 1. The facility failed to ensure Resident #1's bed linens were changed several days between 6/30/2026-7/30/2026. 2. The facility failed to maintain an adequate supply of clean linen that included bed linens and towels, to ensure resident's bedding could be changed when needed and that clean towels were available for residents' showers and personal care. These failures could place residents at risk for an unclean, unsafe, and uncomfortable environment. Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to facility on 08/26/2025. Resident #1 had diagnoses which included unspecified dementia, unspecified severity, with mood disturbance, (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and there is mood changes), muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction), and major depressive disorder, recurrent, moderate (A mental health condition featuring persistent low mood, loss of pleasure in activities ,and changes in energy, experienced 2 or more episodes). Record review of Resident #1's admission MDS, dated [DATE], reflected Resident #1 had a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #1's Comprehensive Care Plan, dated 7/30/2026, reflected a focus area titled The resident has an ADL Self Care Performance Deficit with interventions: bathing: requires staff x 1 for assistance, bed mobility: requires staff x 1 for assistance. Observation and interview conducted on 07/30/2026 at 11:20 AM, the laundry room was observed to have a very little amount of clean laundry, no towels or bed sheets were present in the area. Laundry staff D, who was in the laundry room at the time, stated he believed the facility was low on towels and sheets as he did not see many available. Observation conducted on 07/30/2026 at 11:36 AM, Hall 100 linen closet was observed to have no towels, 1 sheet, and 4 pillowcases. Observation conducted on 07/30/2026 at 11:38 AM, Hall 400 linen closet was observed to have no towels or bed linens. Observation conducted on 07/30/2026 at 11:42 AM, Hall 200 linen closet was observed to have 5 bed sheets, 2 face towels, and 13 bath towels. Observation and interview conducted on 07/30/2026 at 12:06 PM, Hall 300 linen cart was observed with the DON. The cart was observed to have 3 bath towels, 3 wash cloths, and no sheets. The DON stated she had been working for the facility since the beginning of July 2026. She reported the linen shortage had been a consistent problem since she began working at the facility. Also, CNA B on hall 300 stated the facility needed to buy an order of linen because she believed some people were (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	throwing away the linen. She stated it had been a problem for about a month. Interview conducted on 07/30/2026 at 9:35 AM, Resident # 3 stated her roommate, Resident #1 was not getting her linen changed regularly and her family member assisted Resident #1 with getting clean linen on several occasions. Interview conducted on 07/30/2026 at 9:37 AM, Resident # 1 stated her bed linen was supposed to be changed on shower days, three times a week but since she was not getting showered on somedays, the bed linen was not changed. Resident #1 stated she was told there was a shortage of towels which caused missed showers. Resident #1 stated her roommate's family member went and searched for clean linen throughout the facility and could not find any to change her bed linens. Resident #1 stated her bed did not get changed on 6/30/2026, 7/02/2026, 7/04/2026, 7/09/2026, 7/21/2026, and 7/23/2026, she showed the information documented in her journal that she kept daily. Resident #1 stated the situation bothered her. Interview conducted on 07/30/2026 at 10:51 AM, family member to Resident #1's roommate stated there was no clean linen located in the facility on 7/24/2026. The family member stated they had to take linen to their home to wash and return so Resident #1 could have her bed linen changed. The family member stated residents should have clean bed linen and the facility needed to do better job. Interview conducted on 07/30/2026 at 11:25 AM, the HSK Supervisor stated she began working at the facility in June 2026. She reported the facility had been experiencing shortages of linens and towels. She stated she recently received training on ordering linens. The HSK Supervisor stated her supervisor was responsible for placing linen orders until she assumed those duties. She stated she just recently submitted an order for additional linens and offered to provide a copy of the order for review. Interview conducted on 07/30/2026 at 1:26 PM, CNA C stated she was trained in resident rights, she stated residents had the right to live in a clean environment. CNA C stated bed linens were changed when they were dirty and on shower days. She stated they were out of linen lately on hall 100. She stated she would have to grab some from the 300/400 hallways or check with the laundry department. CNA C stated they usually had some linen and towels in the mornings. She stated not having clean linen could cause residents to not feel good, smell bad, or change mood. Interview conducted on 07/30/2026 at 5:36 PM, the ADM stated the linen supply was based on the different shifts and different turnaround times. The ADM stated the turnaround time was two hours for linen to come back from laundry. The ADM stated last month there was a complaint that the linen had run out but not last week to her knowledge, she stated she was not present at the facility last week. The ADM stated some residents' families complained about linen not being changed and when she went to observe and speak with the residents, the residents would say they were changed. The ADM stated her expectations were for residents to have clean bed linens. Record review of Resident #1s PointClickCare (cloud based electronic health record platform for long-term care providers) reflected Resident #1 did not get a shower on 6/30/2026, 7/02/2026, 7/04/2026, 7/09/2026, 7/21/2026, and 7/23/2026, indicative of resident's linen not changed. Record review of facility's linen order on 7/27/2026, reflected a delay shipping date of 08/01/2026. Record review of the facility's, undated, Resident Rights, reflected: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. The facility will (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide the Resident Rights to each newly admitted resident and upon any revision to the Resident Rights to each resident and/or resident representatives.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 7 residents (Resident #1 and Resident #2) reviewed for personal hygiene. 1. The facility failed to provide Resident #1 with 6 scheduled showers between 06/30/2026 and 07/30/2026. 2. The facility failed to provide Resident #2 with 2 scheduled showers on 07/21/2026 and 7/23/2026. These failures could place residents at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. Findings include: 1. Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to facility on 08/26/2025. Resident #1 had diagnoses which included unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction), and major depressive disorder, recurrent, moderate (A mental health condition featuring persistent low mood, loss of pleasure in activities ,and changes in energy, experienced 2 or more episodes). Record review of Resident #1's admission MDS, dated [DATE], reflected Resident #1 had a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #1's Comprehensive Care Plan, dated 7/30/2026, reflected a focus area titled The resident has an ADL Self Care Performance Deficit with interventions: bathing: requires staff x 1 for assistance, bed mobility: requires staff x 1 for assistance. Record review of Resident #1's shower log in PointClickCare (cloud based electronic health record platform for long-term care providers) reflected Resident #1's showers were Tuesdays, Thursdays, and Saturdays, the resident did not receive a shower on 6/30/2026, 7/02/2026, 7/04/2026, 7/09/2026, 7/21/2026, and 7/23/2026. 2. A record review of Resident #2's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility originally 01/03/2025 and readmitted on [DATE]. Resident #2 had diagnoses which included chronic obstructive pulmonary disease (incurable lung disease), Type II diabetes mellitus (body resists the effects of insulin and sugar builds up in blood), anxiety (excessive worry and irritability) and morbid obesity due to excess calories. A record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #2's, undated, Comprehensive Person-Centered Care Plan, reflected, [Resident #2] has an ADL self-care performance deficit with interventions, [Resident #2] requires (assistance by [1]) staff with bathing. Record review of Resident #2's shower log in PointClickCare reflected Resident #2 did not receive her scheduled baths on 7/21/2026 and 07/23/2026. Interview conducted on 07/30/2026 at 9:37 AM, Resident # 1 stated her showers were scheduled for three days a week on Tuesday, Thursday, and Saturday. She stated she had not received her showers as scheduled. She stated when she was home, she showered daily and she understood when she came to the facility it was limited showers. Resident #1 stated it bothered her when she did not get showers on the few days that were scheduled. Resident #1 stated she was told there had been a shortage of towels which caused missed showers. Resident #1 stated she had not received showers on 6/30/2026, 7/02/2026, 7/04/2026, 7/09/2026, 7/21/2026 and 7/23/2026, she showed the information documented in her journal she kept daily. She stated on Tuesday of the prior week (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(7/21/2026) she did not get a shower. She stated CNA A told her she could not give her a shower due to her having the hallway by herself. Resident #1 stated CNA A told her if she got any help, she would shower her, but the shower did not happen. Resident #1 stated she was positive that others were not receiving showers also. Resident #1 stated she and her family member had previously spoken to the ADM about her not getting showers and the ADM advised her to come to her if she did not receive a shower and she would see that she received one. Interview conducted on 07/30/2026 at 11:29 AM, Resident # 2 stated she received her baths this week but last week she missed a few baths. Interview conducted on 07/30/2026 at 1:48 PM, MA E stated she had been with the facility for 2 years. MA E stated when she had some down time she helped on the floor with showers. She stated Resident #2 one day on a Thursday mentioned to her she did not have a bath that day and she offered to help her but Resident #2 said she needed to wait because her family member was coming to visit and she would wait until she laid down. MA E stated she could not get to Resident #2 later that day but told her she would help her on her return to work on that Saturday. MA E further stated Resident #1 mentioned to her a few weeks ago she had not had a shower and she sat in with the resident while she showered. MA E stated residents not getting showers lead to bad hygiene and skin issues. Interview conducted on 07/30/2026 at 3:34 PM, CNA B stated she did work 100-hall on 7/21/2026, however, she did not remember which beds she was assigned for showers/baths on that day without checking. She stated towels were an issue at the facility, which interfered with them not being able to do their jobs as needed. Interview conducted on 07/30/2026 at 4:58 PM, the DON stated some residents complained they did not receive their scheduled baths. She stated providing baths was a struggle during the previous week. The DON stated Resident #1 and Resident #2 had not reported to her that they missed showers or baths. She stated her expectation was that staff provided all residents with showers and baths according to their scheduled bathing days. She stated if a resident refused a bath, staff was expected to notify the nurse. Interview conducted on 07/30/2026 at 5:08 PM, Resident #1's family member stated they had recently met with the facility's IDT. The family member stated Resident #1's scheduled bath days were Tuesdays, Thursdays, and Saturdays; however, she was not consistently receiving her showers. The family member stated this had been frustrating for some time. The family member stated Resident #1 received three showers per week for approximately two weeks, but the issue started again, with the hitting and missing of showers. The family member stated staff turnover appeared to be contributing to the problem. Interview conducted on 07/30/2026 at 5:21 PM, CNA A stated she received training on resident rights and worked at the facility for one year. CNA A stated she had always provided Resident #1 with her scheduled showers. She stated a shower may have been missed if she was working on the hallway by herself. CNA A stated if a shower was missed, she notified the charge nurse. She stated potential harm to a resident who does not receive scheduled showers could include the development of infections. Interview conducted on 07/30/2026 at 5:36 PM, the ADM stated a grievance had previously been filed regarding residents not receiving scheduled showers. The Administrator stated she conducted an in-service with staff following the grievance; however, she stated this occurred some time ago and not recently. The ADM stated the facility had implemented morning champion rounds (department heads speak to residents in the mornings). She stated if a resident reported not receiving a scheduled shower, the concern was discussed during the morning meeting, and they would make sure the resident got a shower. The ADM further stated she just created a shower sign-in sheet for CNAs and residents to document and acknowledge a shower was provided. Record review of the facility's policy on Activities of Daily Living (ADLs), dated 2001, reflected Residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal, and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care).		