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	04/23/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to promote and facilitate resident self-determination through support of resident choices for one (Resident #48) of six residents reviewed for resident rights. The facility failed to promote and facilitate Residents #48's self-determination by not providing the resident with the support needed to get out of bed daily. This failure could place the resident at risk of feelings of depression, lack of self-determination and decreased quality of life. Findings included: Review of Resident #48's face sheet on 4/22/2025, revealed an [AGE] year-old female resident admitted to the facility on [DATE]. The resident's diagnoses included unspecified sequelae of cerebral infarction (a condition that occurs after a stroke), muscle weakness, abnormal posture, anemia, muscle wasting and atrophy, hyperlipidemia (abnormally high levels of fats in the blood), depression, generalized anxiety disorder, and hemiparesis (one-sided muscle weakness resulting from brain or nerve conditions). Review of Resident #48's quarterly MDS dated [DATE], revealed a BIMS Summary Score of 10, which is indicative of moderately impaired cognition. The assessment showed the resident to have experienced feeling down, depressed and hopeless over the last 2 weeks with symptom frequency being 2-6 days (several days) over the last 2 weeks. The resident's functional limitation in range of motion was labeled as impairment on both sides of her upper and lower extremity. The resident was shown to use a wheelchair for mobility. The resident's functional abilities regarding self-care were mostly scored as Substantial/maximal assistance, (Helper does MORE THAN HALF the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort) and Dependent, (Helper does ALL 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). Review of Resident #48's care plan initiated on 9/9/2024 and revised on 3/10/2025, reflected the resident's ADL Self Care Performance Deficit with the goal being that the resident will maintain or improve current level of function in .bed mobility .through the review date. The listed interventions include: Bed Mobility: requires staff x2 for assistance, and The resident requires a mechanical lift x 2 staff for all transfers. (continued on next page)

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

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	04/23/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview of Resident #48 on 4/21/2025 at 2:33 PM, and on 4/22/2025, at approximately 1:00 PM, revealed the resident sitting in her bed, with the bed elevated in such a way that the resident could see and watch television. The resident was observed to be wearing the same pajamas and in the same position in bed on both days. The resident stated that she was dissatisfied with the care she receives at the facility, mostly due to the lack of response by facility staff in meeting her needs and the inconsistency in which she receives basic care. The resident stated that she had not been out of bed in seven days. The resident stated that she has asked to be assisted out of bed every morning for the last seven days with no results. The resident stated that she has told staff it is her preference to get out of bed in the mornings so that she is able to spend as much time as possible out of her bed. Staff will acknowledge the resident's request but say they will have to find another staff member to assist and leave her room. If they return, they do so in the late afternoon right before she needs to be back in bed to eat dinner and prepare for nightly care. The resident stated she feels the staff don't see her request to get out of bed as important. The resident stated that staff provide care and services on their own timeline and according to their own priorities. The resident stated the facility is also shortly staffed which creates a hardship for those residents who require a 2-person assist. During an interview with CNA D on 4/23/2025 at 1:39 PM, CNA D stated that she has been employed with the facility 2 times in the last year. CNA D stated that she has been trained in resident rights and understands the importance of allowing residents to exercise these rights, including the choice as to when they would like to get out of bed. CNA D stated residents can experience negative feelings, feelings of disrespect, and feelings of being unimportant when their choices and rights are disregarded. During an interview with MR/CS/CNA C on 4/23/2025, at 1:45 PM, MR/CS/CNA C stated residents have the right to get up and out of bed at a time of their choosing. However, staffing limitations and equipment availability within the facility don't always allow for their requests to be addressed immediately. During an interview with RN on 4/23/2025 at 1:53 PM, RN stated that she has been a nurse since 1995 and she has been employed as a charge nurse at this facility for 1 year. RN stated she has been trained on resident rights. RN stated self-determination is important because it provides the residents with a sense of empowerment, and it is also their right to get up at a time that is preferable to them. RN stated a shortage in staff contributed to residents not getting the assistance needed to get out of bed and complete ADLs. RN stated a negative outcome of a resident not being able to get out of bed for prolonged periods of time is skin breakdown and a higher risk for falls due to being deconditioned. During an interview with MDSC A on 4/23/2025 at 2:05 PM, MDSC A stated that she has been a nurse for 25 years and has been employed as an MDS Coordinator with this facility since 7/15/2024. MDSC A stated she has been trained on resident rights and in serviced on the topic regularly. MDSC A stated self-determination was important to the residents' overall well-being. Without the ability to exercise self-determination, residents could become depressed and suffer an overall health decline. MDSC A stated the facility experienced a high turnover rate with their aides and this contributed to residents' ADL and mobility needs not being met. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2025 at 2:22 PM with RCN , RCN stated that resident rights are, and self-determination are important to residents as it help prevent a loss of autonomy. RCN stated that there is always enough staff to complete residents' ADLs and meet their mobility needs. During an interview on 4/23/2025 at 2:40 PM, ADM stated resident rights are enforced and regarded within the facility. ADM stated all staff are trained on resident rights as part of their initial orientation and training upon hire and periodically throughout the year in the form of in-service trainings. ADM stated that residents' requests to get up and out of bed should be regarded and assistance provided. ADM stated failure to do so could lead to skin issues and unrealistic fears that their needs aren't going to be met. Review of the facility's Nursing Facility Residents' Rights dated November 2021, stated in part: residents have to the right to be treated with dignity and respect and the right to Be treated with dignity, courtesy, consideration, and respect . The policy also stated residents have a right to participate in their care and the right to Receive all care necessary to have the highest possible level of health.

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	745051	A. Building B. Wing	04/23/2025

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident had a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 6 residents (Resident #1) reviewed for medical record confidentiality. The facility failed to ensure the ADON kept Resident #1's medical information confidential. This failure could place residents at risk of their medical information being provided to unauthorized personnel, other residents, or visitors. Findings include: Record review of the undated Face Sheet for Resident #1 reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes (long-term condition in which the body has trouble controlling blood sugar and using it for energy) without complications. Record review of the Comprehensive MDS for Resident #1 dated 02/17/2025 reflected he had a BIMS score of 5 indicating severe cognitive impairment. Observation on 04/22/2025 from 8:10 AM until 8:13 AM revealed the ADON walked away from the computer screen and into Resident #1 ' s room. The computer screen was left open and facing the hallway exposing Resident #1 ' s confidential medical information including his name and insulin order. In an interview on 04/22/2025 at 8:20 AM the ADON stated she had worked at the facility for two months. She stated Resident #1's name and insulin order were on the open screen; however, she could not remember if his diagnosis was on the screen. She stated she had received on the floor training regarding medication pass but stated everyone knew they should close the computer screens when they were not at their medication carts. She stated she had not received any formal training since she had been at the facility. She stated she might have received HIPAA training but could not remember. In an interview on 04/23/2025 at 1:07 PM the ADM stated her expectation was for confidentiality of the residents to be protected. She stated computer screens should have been closed when not in use and any paperwork with resident information should have been covered. She stated that was protected confidential information and it could have been a HIPAA violation. In an interview on 04/25/2025 at 10:55 AM the DON stated resident information should be kept confidential and if it was not, it would be a HIPAA violation. Record review of the Social Services Manual dated 2003 revised 11/28/2016, reflected, Privacy and confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs for two (Resident #14 and Resident #48) of six residents reviewed for comprehensive care plans. 1. The facility included anticoagulant therapy on the residents' care plans without a recommendation or order for such. 2. The facility failed to include ordered antiplatelet therapy on the residents' care plans. This failure could affect residents by placing them at risk of not receiving appropriate interventions and care to meet their current needs. Findings included: Review of Resident #14's face sheet on 4/22/2025, revealed a [AGE] year-old female resident receiving hospice services, who was admitted to the facility on [DATE]. The resident's diagnoses included senile degeneration of the brain, cognitive communication disorder, polycythemia vera (a rare blood cancer in which bone marrow produces too many red blood cells), abnormalities of gait and mobility, atrial fibrillation (an irregular and often very rapid heart rhythm), Hyperlipidemia (abnormally high levels of fats in the blood), hypertension (high blood pressure), cerebral infarction (stroke), venous insufficiency (damaged valves in the veins), Poly osteoarthritis (arthritis that affects multiple joints at the same time), and obstructive sleep apnea. Review of Resident #14's Quarterly MDS dated [DATE], reflected a BIMS Summary Score of 00, which is indicative of severe cognitive impairment, with limited ability to understand or be understood. In addition, the assessment indicated the resident was taking an antiplatelet medication. The assessment did not indicate the resident was taking an anticoagulant medication. Review of Resident #14's Order Summary Report on 4/22/2025, reflected an active order for Aspirin 81 Oral Tablet Chewable (Aspirin), used for antiplatelet therapy, dated 11/30/2024. Further review of Resident #14's Order Summary Report revealed no orders for any anticoagulant medication(s). Review of Resident #14's care plan, initiated on 7/7/2024 and revised on 1/25/2025, revealed, The resident is on [Anticoagulant] therapy with the goal being The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. The listed interventions did not include the administration of an anticoagulant medication, but the plan did include an intervention initiated on 7/7/2024, to Monitor/document/report to MD PRN s/sx of anticoagulant complications . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #14 on 4/21/2025, at 11:00 AM, and 4/22/2025 , revealed the resident to be sitting in her room in her wheelchair watching tv. The resident was dressed in clothing appropriate for the day with no concerns noted for her appearance or hygiene. The resident was unable to participate in conversation or answer questions asked of her as evidenced by her lack of response and eye contact, and her mumbling of incoherent phrases to herself while looking up at the ceiling. Review of Resident #48's face sheet on 4/22/2025, revealed an [AGE] year-old female resident admitted to the facility on [DATE]. The resident's diagnoses included unspecified sequelae of cerebral infarction (a condition that occurs after a stroke), muscle weakness, abnormal posture, anemia, muscle wasting and atrophy, hyperlipidemia (abnormally high levels of fats in the blood), depression, generalized anxiety disorder, and hemiparesis (one-sided muscle weakness resulting from brain or nerve conditions). Review of Resident #48's quarterly MDS dated [DATE], revealed a BIMS Summary Score of 10, which is indicative of moderately impaired cognition. In addition, the assessment indicated the resident was taking an antiplatelet medication. The assessment did not indicate the resident was taking an anticoagulant medication. Review of Resident #48's Order Summary Report on 4/22/2025, reflected an active order for Aspirin 81 Oral Tablet Chewable (Aspirin), used for antiplatelet therapy, dated 11/30/2024. Further review of Resident #48's Order Summary Report revealed no orders for any anticoagulant medication(s). Review of Resident #48's care plan initiated on 10/16/2024, and revised on 4/17/2025, revealed The resident is on [Anticoagulant] therapy with the goal being The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. The listed interventions did not include the administration of an anticoagulant medication, but the plan did include an intervention initiated on 7/7/2024 , to Monitor/document/report to MD PRN s/sx of anticoagulant complications . Observation and interview of Resident #48 on 4/21/2025 at 2:33 PM, and on 4/22/2025, at approximately 1:00 PM, revealed the resident sitting in her bed, with the bed elevated in such a way that the resident could see and watch television. The resident stated that she was included in the development of her care plan, but she could not confirm the contents or the accuracy of the plan. The resident stated she is familiar with her prescribed medications and believes she receives those medications daily. During an interview with CNA D on 4/23/2025 at 1:39 PM, CNA D stated that she has been employed with the facility 2 times in the last year. CNA D stated that she is typically assigned to care for the same residents, in the same hall during her assigned shifts so she has become familiar with the extent of their care and needs. CNA D stated the care plan is the basis for all care and treatment provided to the residents. CNA D stated that she has received training on care plan review in the past. CNA D stated that changes, corrections, and/or updates to the residents' care plans are typically communicated verbally between staff while reporting off to the oncoming staff member at the change of shifts. CNA D said residents could suffer negative consequences such as not receiving sufficient care required to meet their needs if their care plans are inaccurate or not followed. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MR/CS/CNA C on 4/23/2025, at 1:45 PM, MR/CS/CNA C stated that she has been employed with the facility in different capacities and has been trained on care planning and the significance of an accurate care plan. MR/CS/CNA C stated that she gets the support and training by facility leadership to perform her job duties. MR/CS/CNA C stated that care plans should be reviewed prior to providing care to a resident. MR/CS/CNA C stated that changes to a resident's care plan are communicated verbally between nursing staff. MR/CS/CNA C said it is important that the care plans accurately reflect the resident's needs to ensure they receive proper care to meet those needs. If a resident's care plan is incorrect, this could have a negative impact on the resident and the care they receive. MR/CS/CNA said any inaccuracies or contradictions in the physician's orders, MDS data, or notes should be cross referenced, verified, and reported to the nurse so that corrections can be made. During an interview with RN on 4/23/2025 at 1:53 PM, RN stated that she has been a nurse since 1995 and she has been employed as a charge nurse at this facility for 1 year. RN stated that she has been trained on resident care and is familiar with care plans . RN said it is important that care plans are accurate as this keeps treatment providers on the same page regarding residents' goals, wants, and desires. RN stated that inaccurate care plans pose a risk to the residents in that they may not receive the necessary care. RN said it is the responsibility of all to make sure care plans are up to date and followed. RN stated that changes to the care plan are usually communicated directly by the person who is managing the change to those providing the care. RN stated that care plan changes are also communicated while giving report and are captured in the resident's electronic medical record. During an interview with MDSC A on 4/23/2025 at 2:05 PM, MDSC A stated that she has been a nurse for 25 years and has been employed as an MDS Coordinator with this facility since 7/15/2024. MDSC A stated that it is her responsibility to ensure the residents are accurately assessed to ensure they are receiving all services and supports necessary to support their health and well-being. MDSC A stated that care plans are an important component of resident care because they dictate how to care for the residents. MDSC A stated that care plan errors should be reported to any nurse once discovered. MDSC A stated upon admission the residents are provided with a copy and explanation of their care plan. During quarterly reviews care plans are reviewed for updates and accuracy as well. MDSC A stated that floor care in accordance with the care plan is the responsibility of the floor care nurses. MDSC A stated that she utilizes a communication form system to notify the different departments of changes to residents' care and needs. During the interview with MDSC A she was advised of the inaccuracies in the care plans of Residents #14 and #48 . MDSC A reviewed the residents' care plans and determined the former Director of Nursing and former Corporate Compliance Nurse triggered the wrong focus areas for the residents. MDSC A confirmed neither resident was taking an anticoagulant medication, rather an antiplatelet medication (Aspirin). MDSC A corrected the residents' care plans and stated this would be communicated to the floor nurses. MDSC A stated that the potential risk to the residents is minimal as the signs and symptoms of the adverse effects and the interventions are the same. However, MDSC A stated that it is important to correct the mistakes for classification purposes and because the residents' records need to accurately reflect the care they need. During an interview on 4/23/2025 at 2:22 PM with RCN , RCN stated that staff are taught to review residents' care plans regularly as this serves as their guide to the residents' care. RCN stated that staff should always review the residents' care plan if there is a known change or upon a new admission. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2025 at 2:22 PM with DON, DON stated care plan information is derived from admission and ongoing assessment information. DON stated that an inaccurate assessment could lead to an inaccurate care plan. DON acknowledged that an inaccurate care plan could also be the result of a care area being triggered by mistake. The DON stated the negative impact this could have on the residents was inaccurate care. During an interview on 4/23/2025 at 2:40 PM, ADM stated that the MDS Coordinators should be ensuring the accuracy of resident care plans. ADM stated that care plans should be reviewed every 90 days for accuracy. If this is not done, this could lead to an inaccurate reflection of care and care providers could miss something .

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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 observations, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 9 of 23 residents (Resident # 6, #15, #17, # 24, # 28, #45, # 66, #72, #76) reviewed for ADL care. The facility failed to provide showers as scheduled for Residents # 6, #15, #17, # 24, # 28, #45, # 66, #72, and #76. This failure could place residents who were unable to carry out ADLs independently, at risk of skin breakdown, pain, and infection. Findings included: 1. Record review of face sheet dated 4/22/25 for Resident # 6 reflected she was an [AGE] year old female admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood, leading to low blood oxygen levels), dysphagia (difficulty swallowing food or liquids), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar levels), cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention, memory, and reasoning), hypertension (high blood pressure), hyperlipidemia (increased fat particles in the blood), muscle weakness, lack of coordination, abnormal posture, and congestive heart failure (a condition where the heart can't pump blood effectively enough to meet the body's needs). Review of Quarterly MDS for Resident # 6 dated 3/13/25 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG-Functional Abilities reflected she was totally dependent for toileting, required substantial/maximal assistance for transfers and lower body dressing, and required partial/moderate assistance for personal hygiene, bathing, and upper body dressing. Review of Care Plan for Resident # 6 dated 1/6/25 reflected an ADL self-care deficit and required supervision as needed for bathing. Review of POC Task Care Record for the month of April 2025 reflected Resident # 6 was to have bathing on Tuesday, Thursday, and Saturday days. Resident # 6 had documented baths on Tuesday 4/8/25 and Thursday 4/10/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 4/21/25 at 11:32 AM with Resident # 6, Resident was up in her wheelchair neatly groomed. Resident has concerns because of low staff on Easter day and she stated there were only 2 staff in the building. Resident stated her call light was answered at 10 and turned off by an aide. She said she was told by the aide, I will be back with the aide not returning. Resident stated her call light was then answered again at 11. The call light was turned off by an aide and the aide stated, I will be back to help you. At 11:30 the resident was changed and got up from bed. Resident stated they were last changed at 4:30 am prior to finally being changed at 11:30 am. Resident said her showers are T, TH, SAT and she only received 1 shower a week. Resident stated the last shower she received was last Thursday 4/17/25 and there was a conflict with a doctor appointment and it was very rushed. Resident said the shower before that was on 4/9/25. Resident stated the aides lie about giving showers. 2. Record review of Resident #15's undated face sheet reflected a [AGE] year-old male, admitted on [DATE], and his diagnoses included: Cerebrovascular disease (conditions that affect the blood vessels of the brain), Chronic heart failure, type 2 diabetes (high blood sugar), morbid (severe) obesity (Body Mass Index of 40 or greater), major depression, and epilepsy (seizure disorder). Record review of Resident #15's MDS assessment dated [DATE] indicated a BIMS score of 10, indicating moderate cognitive impairment. Section GG- Functional Abilities reflected he required extensive assistance - resident involved in activity, staff provide weight-bearing support and two-person physical support. Record review of Resident #15's care plan dated, 01/31/2025 indicated he had an ADL Self Care Performance Deficit and required CNA for personal hygiene; walking: provide supervision as needed assist as needed. During bathing and dressing, Resident #15 required staff x2 for assistance and mechanical lift for transfers. An observation and interview on 04/21/2025 , revealed Resident #15 was laying in his bed, and he stated he was ready to get up, but he was told by the aide that she needed to find help. Resident # 15 stated he had not had a shower and he did not know his shower schedule. He stated the aides would give him a bed bath because it is easier for them, but he preferred to have a shower because he is a large man. He stated it is difficult for staff to give him a shower because he required 2 staff to get him out of bed and they must transfer him with a mechanical lift. 3. Record review of Resident # 17's undated face sheet reflected she was [AGE] years old, admitted on [DATE], and her diagnoses included Huntington's disease (brain cells slowly lose function and die), dementia without behavior disturbance (loss of memory, thinking without behavioral symptoms), Depression (mental health disorder), Bradycardia (heart rate lower than normal), and schizophrenia (disruptions in thought process, perceptions). (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's admission MDS assessment dated [DATE] indicated a BIMS score of 12, indicating moderate cognitive impairment. Section GG- Functional Abilities reflected during showers- she required substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. During Personal hygiene and dressing: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face, and hands (excludes baths, showers, and oral hygiene) required Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident. completes activity. Record review of Resident #17's care plan dated 02/07/2025 indicated she had an ADL self-care performance deficit and required CNA for personal hygiene; walking: provide supervision as needed assist as needed. Review of a task schedule dated April 2025 for Resident #17 reflected she was to have bathing on Monday, Wednesday, and Friday evening shift. She had documented baths on Friday 4/4/2025. Interview and observation on 04/21/25 at 10:23 AM revealed Resident #17 came out of her room and loudly stated, get me out of her . Resident # 17's hair was dismantled and stiff, and her face was dry and dirty. She stated, I have not had a shower, and something needs to be done about this place. She stated she did not know why she was not given a shower. Observation on 04/22/2025 at 1:30PM revealed Resident # 17 had the same clothes on since 04/21/2025, her hair was dismantled and stiff, and her face was dry and dirty. Observation and interview on 04/23/25 at 11:16 AM, revealed Resident # 17 came out of her room and walked the hallway and then she went back to her bed. Resident #17 had the same clothes on for 3 days (04/21/2025- 04/23/2025), and her hair was untidy. Resident stated she had not been showered all week and the staff did not help her change her clothes. She stated, I would like to take a shower. Review of a task schedule dated April 2025 for Resident # 17 reflected no documentation found in his electronic heath records. 4. Review of the undated Face Sheet for Resident #24 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic kidney disease, stage 5 (when kidneys stop functioning), Heart Failure, Type 2 Diabetes (long term condition in which the body has trouble controlling blood sugar and using it for energy) with chronic kidney disease, and Morbid (severe) Obesity. Review of the Quarterly MDS for Resident #24 dated 04/12/2025 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG- Functional Abilities reflected she was dependent for all activities in bed. She had not attempted tub/shower transfer due to medical condition or safety concerns. (continued on next page)

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	04/23/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan for Resident #24 dated 02/24/2025 reflected she needed hemo (blood) dialysis related to renal (kidney) failure. She went to dialysis on Tuesdays, Thursdays, and Saturdays. She had an ADL self-care deficit and required one staff for bathing assistance. Review of the POC Response history reflected Resident #24 had received her last documented bed bath on 03/25/2025. Review of a task schedule dated April 2025 for Resident #24 reflected she was to have bathing on Monday, Wednesday and Friday evenings. She had documented baths on Monday 4/7/2025, and Friday 4/18/2025. In an interview on 04/21/2025 at 10:00 AM Resident #24 stated some nurse's aides refused to give her an evening bath. She further stated, at the worst, I only got one bath a week. In an interview on 04/23/2025 at 10:43 AM MR A stated Sometimes we have a problem with staffing on the weekends. The staff don't call in and they don't show up. 5. Record review of face sheet dated 4/22/25 for Resident # 28 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves), abnormal posture, lack of coordination, anemia (lack of red blood cells), muscle weakness, hypokalemia (low blood potassium), hypertension (elevated blood pressure), dysphagia (difficulty swallowing food and liquids), cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention, memory, and reasoning), major depressive disorder (clinical depression), adjustment disorder, legal blindness, neuromuscular dysfunction of the bladder, and enterocolitis due to clostridium difficile (an inflammation of the small intestines and the colon). Record review of Quarterly MDS for Resident # 28 dated 4/4/25 reflected a BIMS score of 10 indicating moderate cognitive impairment. Section GG- Functional Abilities reflected total dependence for toileting, bathing, dressing, personal hygiene, and transfers. Record review of Care Plan for Resident # 28 dated 11/14/24 reflected he had an ADL self-care performance deficit with interventions of bathing, mobility, toileting, and dressing requiring X2 staff assistance. Resident has bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide peri care after each incontinent episode. See care plan on mobility, ADLs, cognitive deficit, and communication. Record review of POC Task Care Record for the month of April 2025 reflected Resident # 28 was to have bathing on Tuesday, Thursday, and Saturday days. Resident # 28 had documented baths on 4/8/25, 4/10/25, and 4/19/25. Resident # 28 was to have toileting, personal hygiene, transferring, and turn/reposition documented every shift. Resident # 28 had no toileting, personal hygiene, transferring, and turn/reposition documented for 4/1/25, 4/5/25, 4/11/25, and 4/17/25. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 4/21/25 at 1:35 PM with Resident # 28, Resident was up in his motorized wheelchair in his room, neatly groomed. Resident stated his main concern is with lack of staffing having to wait a long time for assistance. Facility not having a standing lift and him having to wear briefs and have bowel movements on himself and wait forever for staff to come change him . Resident has concerns about receiving showers timely and as scheduled. 6. Review of the undated Face Sheet for Resident #45 reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses were Cellulitis (bacterial skin infection) of the left lower limb, acute and chronic Respiratory failure with hypoxia (condition where lungs are unable to effectively exchange oxygen and carbon dioxide, leading to chronically low oxygen levels in the blood), Pressure Ulcer of the sacral region (bone at the base of the spine) stage 4 (full thickness skin loss with exposed bone, tendon or muscle), and Type 2 Diabetes Mellitus (long term condition in which the body has trouble controlling blood sugar and using it for energy with diabetic neuropathy (nerve damage caused by chronically high blood sugar levels). Review of the Quarterly MDS for Resident #45 dated 04/12/12025 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG - Functional Abilities reflected she was dependent on staff for showering and bathing, and chair/bed-to-chair transfer. She used a manual wheelchair. Review of the Care Plan for Resident #45 dated 01/15/2025 reflected she had an ADL self-care performance deficit. Interventions dated 03/08/2025 included The resident is totally dependent on staff to provide a bath and 01/15/2025 Transfer: the resident requires mechanical lift X 2 staff. Review of the POC Response history reflected Resident #45 had received her last documented bed bath on 03/31/2025. Review of a task schedule dated April 2025 for Resident #45 reflected she was to have bathing on Monday, Wednesday and Friday day shift. She had documented baths on Monday 4/7/2025, and Friday 4/18/2025. In an interview on 04/21/2025 at 9:00 AM Resident #45 stated it had been a week since she had a bath. She stated she was supposed to receive a bath on Monday, Wednesday and Fridays but there was not enough help in the facility. In an interview on 04/22/2025 at 12:30 PM Resident #45 stated she had received a bath on Monday 4/21/2025 in the evening but she thought it had been one week prior when she had received her last bath. She stated not receiving a bath made her feel icky. 7. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of face sheet dated 4/22/25 for Resident # 66 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood leading to low blood oxygen levels), pneumonia, muscle weakness, lack of coordination, cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention, memory, and reasoning), hyperlipidemia (increased fat particles in the blood), dysphagia (difficulty swallowing food and liquids), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy), dementia (a group of thinking and social symptoms that interferes with daily functioning), abnormalities of gait and mobility, insomnia (persistent problems falling and staying asleep), and obstructive sleep apnea (intermittent airflow blockage during sleep). Record review of the Comprehensive MDS dated [DATE] for Resident # 66 reflected a BIMS score of 2 indicating severe cognitive impairment. Section GG - Functional Abilities reflected he was totally dependent on staff for toileting and bathing. Substantial/maximal assistance was required for transfers, personal hygiene, and dressing. Record review of Care Plan for Resident # 66 dated 4/7/25 reflected Resident # 66 has bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide peri care after each incontinent episode. See care plan on mobility, ADLs, cognitive deficit, and communication. Resident has an ADL self-care performance deficit with interventions of bathing and bed mobility require staff x1 for assistance and toileting required supervision as needed. Record review of POC Task Care Record for the month of April 2025 reflected Resident #66 was to have bathing on Tuesday, Thursday, and Saturday days. Resident # 66 with documented baths on 4/4/25, 4/8/25, and 4/10/25. Resident # 66 was to have toilet use, personal hygiene, transferring, bed mobility, bowel continence, and ADL assistance documented each shift. Resident # 66 had no documentation for toilet use, personal hygiene, transferring, bed mobility, bowel continence, and ADL assistance on 4/5/25, 4/11/25, and 4/19/25. In an interview on 4/21/25 at 2:24 PM with Resident # 66's RP revealed RP stated she has concerns because at the time of Resident # 66 admission staff were unaware resident had even admitted to the facility for the first 5 hours. RP stated she came into the room and Resident #66 was in the dark, so she turned the room light on, and a staff member came in and stated, I did not even know there was a resident in this room. RP stated the facility is always greatly understaffed. When resident eats in his room staff are not present to help even though resident admitted due to aspiration pneumonia . RP stated last week she notified the ADM that the resident was lying in bed and had not been changed for over 4 hours. RP stated Therapy came to get the resident while RP was present, and resident was soaked in urine all the way up the back of his shirt. RP stated when staff are here, they are good about helping and providing care but the problem was there were many times there was no staff present. RP stated the staffing issues are during the week and on the weekends. 8. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of face sheet dated 4/22/25 for Resident # 72 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of quadriplegia (a paralysis that affects the ability to voluntarily move the upper and lower body), osteomyelitis (inflammation of the bone caused by infection), pressure ulcer of sacral region stage 4 (bedsores on the buttocks that involves full thickness skin and tissue loss), muscle weakness, anemia (lack of red blood cells), lack of coordination, acute bronchitis (a short term inflammation of the lungs bronchial tubes), and anxiety disorder. Record review of Quarterly MDS for Resident # 72 dated 3/7/25 reflected a BIMS score of 15 indicating intact cognitive status. Section GG - Functional Abilities reflected he was totally dependent for toileting, bathing, dressing, and transfers. Resident # 72 required substantial maximal assistance for personal hygiene. Record review of Care Plan for Resident # 72 dated 12/31/24 reflected Resident # 72 has bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide peri care after each incontinent episode. See care plan on mobility, ADLs, cognitive deficit, and communication. Resident # 72 has an ADL self-care deficit with interventions of bathing, bed mobility, toileting, and dressing of staff x2 for assistance. Resident # 72 requires a lift for all transfers. Record review of POC Task Care Record for the month of April 2025 reflected Resident #72 was to have bathing on Monday, Wednesday, and Fridays. Resident # 72 with documented baths on 4/3/25, 4/8/25, and 4/14/25. Resident was to have toilet use, personal hygiene, bowel continence, transferring, bed mobility, and ADL assistance documented each shift. Resident # 72 had no documentation for toilet use, personal hygiene, bowel continence, transferring, bed mobility, and ADL assistance on 4/1/25, 4/5/25, 4/6/25, 4/8/25, 4/11/25, and 4/19/25. In an observation and interview on 4/21/25 at 3:45 PM with Resident # 72Resident was up in his motorized wheelchair outside in front of the building visiting with fellow residents. Resident has concerns about staffing and stated it has been a problem since the end of last year. Resident stated his shower days are M, W, F in the evening. Resident stated he is supposed to get bed baths on these days. Resident stated he has not received a bath in a week. Resident states the call response time is slow, and you must wait several hours before anyone comes to see what is needed. 9. Record review of Resident #76 's undated face sheet reflected he was [AGE] years old, admitted on [DATE], and his diagnosis included: type 2 diabetes. Record review of Resident # 76 's quarterly MDS assessment dated [DATE] indicated a BIMS score of 13 indicating intact cognitive response. Section GG- Functional Abilities reflected he required Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance. Resident #76 required one-person physical assist. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/21/25 at 11:33 AM Resident #76 stated he did not want to complain but he had his first shower since his admission [DATE]) the day before Easter (04/19/2025). He stated there is not enough staff to help him with a shower because he required two staff assist and he is transferred by mechanical lift. He stated sometimes the staff would give him a bed bath because it is easier for them. An observation and interview on 04/23/25 at 11:18 AM, revealed Resident # 76 was laying in his bed listening to music in his phone. He stated he was supposed to get a shower last night (04/22/25) and he did not. Review of a task schedule dated April 2025 for Resident #76 reflected he was to have showers on Tuesday, Thursday, and Saturday day shift. He had documented baths on Saturday April 5th, Thursday April 10th, and Saturday April 19th. In an interview on 04/22/25 at 2: 16PM, CNA F , stated some of the resident's shower schedules are split between morning and shift showers . She stated she had not given showers to anyone beside one resident because she had an accident and needed a shower. She stated she thought an aide was assigned to shower assignments in the evenings, but she was not sure if showers were given. CNA F stated, to be honest I have not given a lot of showers and there is not enough of staff to help. I do not know how to document showers and I do not know who my supervisor is to ask for help. In an interview on 04/22/2025 at 02:25PM with CNA G she stated she had only worked for 2 days and was in on the job training. She stated she thought there was a shower tech who came in the morning, but she had not seen any one take showers since she started this week. In an interview on 04/23/2025 at 10:58AM with CNA K she stated they have been told to find another staff on another hall when they need help with showers and when they need to get a Resident who requires a 2 person assist for showers and mobility transfers. She stated she was not sure if Resident # 15 had a shower because he required a mechanical lift and the majority of the time the battery is not charged. She stated she would guess the CNAs are responsible for ensuring the mechanical lifts are charged but no one has ever told her who was responsible. She stated showers should be documented in POC and if a resident should get a bed bath it would be in POC. She stated she did not believe showers are given as scheduled because they are always short on staff and people call in a lot. In an interview on 04/23/25 at 2:37 PM with RN she stated, the CNAs will tell her if residents refused shower. She stated CNAs should document showers under task in POC but she could not say if they are documenting or not. She stated when there are concerns regarding showers not given the DON or ADON is notified. She stated she had no documentation showing showers were not given. She stated they used to have a shower book at the nursing station for CNAs to review related to shower schedules and refusals, but she was not sure if it was still there. She stated it is bad if the CNAs are not giving showers because it can affect the resident's skin integrity. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/23/25 at 2:45 PM with DON, she stated the CNAs are primarily responsible for residents' baths/ showers. She stated all staff was trained to go into the POC task list and document showers and her expectations are for staff to provide showers. She stated if showers are not given the DON and ADON were responsible for following up with the CNAs and determining why (e.g. refusals or not given). She stated the CNAs are instructed to go to another hall and request assistance from another CNA, Nurse, or Med Aide, and they have all been made aware to do so. She stated the DON and ADON supervise the CNAs and monitor showers/ baths in POC. She stated they are monitored and reviewed in their morning stand -up meeting . She stated she was not aware that showers/ baths were not documented, and CNAs should document if a resident refused to take a shower and inform the charge nurse. Record review of ADL policy attempted and requested on 4/22/25 and 4/23/25 from ADM. A policy was not provided prior to exit.

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	745051	A. Building B. Wing	04/23/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 9 (Residents #6, #11, #24,#28, #45, #66, #72, #73, #76) of 20 residents reviewed for sufficient staffing. The facility failed to ensure the facility had sufficient staffing to meet the needs of Residents #6, #11, #24, #28, #45, #66, #72, #73, #76. This failure could place the residents at risk of resident's needs, safety, and psychosocial well-being not being met. Findings included: 1. Record review of the face sheet dated 4/22/25 for Resident # 6 reflected she was an [AGE] year old female admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood, leading to low blood oxygen levels), dysphagia (difficulty swallowing food or liquids), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar levels), cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention memory and reasoning), hypertension (high blood pressure), hyperlipidemia (increased fat particles in the blood), muscle weakness, lack of coordination, abnormal posture, and congestive heart failure (a condition where the heart can't pump blood effectively enough to meet the body's needs). Review of the Quarterly MDS for Resident # 6 dated 3/13/25 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG-Functional Abilities reflected she was totally dependent for toileting, substantial/maximal assistance for transfers and lower body dressing, partial/moderate assistance for personal hygiene, bathing, and upper body dressing. Review of the Care Plan for Resident # 6 dated 1/6/25 reflected an ADL self-care deficit and required supervision as needed for bathing. Review of POC Task Care Record for the month of April reflected Resident # 6 was to have bathing on Tuesday, Thursday, and Saturday, days. Resident # 6 had documented baths on Tuesday 4/8/25 and Thursday 4/10/25. Record review of Resident # 6 progress notes for April and found no refusals documented. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 4/21/25 at 11:32 AM with Resident # 6 revealed the resident up in her wheelchair neatly groomed. The resident had concerns because of low staff on Easter day. She stated only 2 staff were in the building. The resident stated her call light was answered at 10, turned off by an aide, and told by Aide I will she be back but the aide did not return. The resident stated her call light was then answered again at 11, the call light was turned off by the aide, and the aide stated, I will be back to help you Resident stated at 11:30 a CNA returned, and resident was changed and got up from bed. Resident stated they were last changed at 4:30 am prior to finally being changed at 11:30 am. Showers were T, TH, SAT and only received 1 shower a week. The resident stated the last shower received was last Thursday 4/17/25. It conflicted with her doctor appointment and was a very rushed shower, before that shower the last one was on 4/9/25. The resident stated the aides lie about giving showers. On this past Saturday due to low staff. the residents were told no dining room meals would be served and all the residents had to eat in their rooms for breakfast. On 4/16/25, Resident # 6 stated her morning medications were not administered until 1:20 pm. 2. Record review of a face sheet dated 4/21/25 for Resident #11 reflected she was an [AGE] year old female admitted to the facility on [DATE] with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (clinical depression), hypertension (elevated blood pressure), hypothyroidism (underactive thyroid), chronic pain, atrial fibrillation (irregular heart rate), osteoporosis (a condition in which the bones become weak and brittle), anemia (lack of blood), heart disease, and tremor. Record review of the Quarterly MDS for Resident # 11 dated 3/6/25 reflected a BIMS score of 9 indicating moderate cognitive impairment. Section GG-Functional Abilities reflected she required supervision or touching assistance for toileting, bathing, dressing, and transfers. Record review of the Care Plan for Resident # 11 dated 3/30/24 reflected an ADL self-care deficit and required supervision as needed for bathing, toileting, and transfers. Record review of Resident # 11 progress notes for April and found no refusals documented. In an observation and interview of Resident # 11 on 4/21/25 at 11:44 AM revealed the resident in her room sitting on the edge of her bed watching tv. The resident appeared to be neatly groomed. The resident stated she did not receive any medications until 1:00 pm. The resident stated this was due to not having enough MA's. The resident stated the only MA has put in her 2-week notice. The Resident stated the facility has not had MA staff for a couple of weeks. In an interview on 4/22/25 at 9:30 AM with Resident # 11 's RP revealed the RP stated she had concerns about Resident # 11 not getting medications. The RP stated she was concerned because other residents' family members were staying at the facility until 3am because staffing was just not there. The RP stated the weekend staffing was terrible. The RP had concerns because Resident # 11 did not get medications on 4/19/25 Saturday night until the DON came up and started passing medications at 11 pm. On Wednesday, 4/16/25, the RP stated she was told by the facility staff that morning medications were to be given before noon and then it would still be considered morning. The RP stated her mother did not receive her medications on 4/16/25 until 1:00 pm. 3. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated Face Sheet for Resident #24 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic kidney disease, stage 5 (when kidneys stop functioning), heart failure, type 2 diabetes (long term condition in which the body has trouble controlling blood sugar and using it for energy) with chronic kidney disease, and morbid (severe) obesity. Review of the Quarterly MDS for Resident #24 dated 04/12/2025 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG- Functional Abilities reflected she was dependent for all activities in bed. She had not attempted tub/shower transfer due to medical condition or safety concerns. Review of the Care Plan for Resident #24 dated 02/24/2025 reflected she needed hemo (blood) dialysis related to renal (kidney) failure. She went to dialysis on Tuesdays, Thursdays, and Saturdays. She had an ADL self-care deficit and required one staff for bathing assistance. Review of the POC Response history reflected Resident #24 had received her last documented bed bath on 03/25/2025. Review of a task schedule dated April 2025 for Resident #24 reflected she was to have bathing on Monday, Wednesday, and Friday, evenings. She had documented baths on Monday 4/7/2025, and Friday 4/18/2025. Record review of Resident # 24 progress notes for April and found no refusals documented. In an interview on 04/21/2025 at 10:00 AM Resident #24 stated there was not enough help on the weekends and not enough help to get her out of bed as she needed to use a (mechanical) lift and it takes two people. She stated an (unnamed) aide told her staffing was short on Easter weekend as a lot of staff had called to say they were not coming in. She stated some nurse's aides refused to give her an evening bath. She further stated, at the worst, I only got one bath a week. In an interview on 04/23/2025 at 10:43 AM the MR A stated Sometimes we have a problem with staffing on the weekends. The staff don't call in and they don't show up. 4. Record review of the face sheet dated 4/22/25 for Resident # 28 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves), abnormal posture, lack of coordination, anemia (lack of blood), muscle weakness, hypokalemia (low blood potassium), hypertension (elevated blood pressure), dysphagia (difficulty swallowing food and liquids), cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention memory and reasoning), major depressive disorder (clinical depression), adjustment disorder, legal blindness, neuromuscular dysfunction of the bladder, and enterocolitis due to clostridium difficile (an inflammation of the small intestines and the colon). Record review of the Quarterly MDS for Resident # 28 dated 4/4/25 reflected a BIMS score of 10 indicating moderate cognitive impairment. Section GG- Functional Abilities reflected total dependence for toileting, bathing, dressing, personal hygiene, and transfers. (continued on next page)

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	04/23/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Care Plan for Resident # 28 dated 11/14/24 reflected he had an ADL self-care performance deficit with interventions of bathing, mobility, toileting, and dressing requiring X2 staff assistance. Resident has bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide perineal care after each incontinent episode. See care plan on mobility, ADL's, cognitive deficit, and communication. Record review of POC Task Care Record for the month of April reflected Resident # 28 was to have bathing on Tuesday, Thursday, and Saturday, days. Resident # 28 had documented baths on 4/8/25, 4/10/25, and 4/19/25. Resident # 28 to have toileting, personal hygiene, transferring, and turn/reposition documented every shift. Resident # 28 had no toileting, personal hygiene, transferring, and turn/reposition documented for 4/1/25, 4/5/25, 4/11/25, and 4/17/25. Record review of Resident # 28 progress notes for April and found no refusals documented. In an observation and interview on 4/21/25 at 1:35 PM with Resident # 28 revealed the resident up in his motorized wheelchair in his room neatly groomed. The resident stated his main concern was with lack of staffing. Him having to wait a long time for assistance, the facility not having a standing lift, him having to wear briefs and have bowel movements on himself and wait forever for staff to come change him. The resident had concerns about receiving showers timely and as scheduled. 5. Review of the undated Face Sheet for Resident #45 reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses were cellulitis (bacterial skin infection) of the left lower limb, acute and chronic respiratory failure with hypoxia (condition where lungs are unable to effectively exchange oxygen and carbon dioxide, leading to chronically low oxygen levels in the blood), pressure ulcer of the sacral region (bone at the base of the spine) stage 4 (full thickness skin loss with exposed bone, tendon or muscle), and type 2 diabetes mellitus (long term condition in which the body has trouble controlling blood sugar and using it for energy with diabetic neuropathy (nerve damage caused by chronically high blood sugar levels). Review of the Quarterly MDS for Resident #45 dated 04/12/12025 reflected she had a BIMS score of 14 indicating intact cognitive status. Section GG - Functional Abilities reflected she was dependent on staff for showering and bathing, and chair/bed-to-chair transfer. She used a manual wheelchair. Review of the Care Plan for Resident #45 dated 01/15/2025 reflected she had an ADL self-care performance deficit. Interventions dated 03/08/2025 included The resident is totally dependent on staff to provide a bath and 01/15/2025 Transfer: the resident requires mechanical lift X 2 staff. Review of the POC Response history reflected Resident #45 had received her last documented bed bath on 03/31/2025. Review of a task schedule dated April 2025 for Resident #45 reflected she was to have bathing on Monday, Wednesday, and Friday, day shift. She had documented baths on Monday 4/7/2025, and Friday 4/18/2025. Record review of Resident # 45 progress notes for April and found no refusals documented. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/21/2025 at 9:00 AM Resident #45 stated it had been a week since she had a bath. She stated she was supposed to receive a bath on Monday, Wednesday, and Fridays but there was not enough help in the facility. She stated staff did not get her up a lot as she required a mechanical lift and there had to be two people to safely lift her. She further stated she would like to get up at least once a day. In an interview on 04/22/2025 at 12:30 PM Resident #45 stated she had received a bath on Monday 4/21/2025 in the evening but she thought it had been one week prior when she had received her last bath. She stated not receiving a bath made her feel icky. 6. Record review of the face sheet dated 4/22/25 for Resident # 66 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood leading to low blood oxygen levels), pneumonia, muscle weakness, lack of coordination, cognitive communication deficit (difficulties in communication stemming from problems with cognitive functions such as attention memory and reasoning), hyperlipidemia (increased fat particles in the blood), dysphagia (difficulty swallowing food and liquids), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy), dementia (a group of thinking and social symptoms that interferes with daily functioning), abnormalities of gait and mobility, insomnia (persistent problems falling and staying asleep), and obstructive sleep apnea (intermittent airflow blockage during sleep). Record review of the Comprehensive MDS dated [DATE] for Resident # 66 reflected a BIMS score of 2 indicating severe cognitive impairment. Section GG - Functional Abilities reflected he was totally dependent on staff for toileting and bathing. Substantial/maximal assistance required for transfers, personal hygiene, and dressing. Record review of the Care Plan for Resident # 66 dated 4/7/25 reflected Resident # 66 has bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide perineal care after each incontinent episode. See care plan on mobility, ADL's, cognitive deficit, and communication. The resident has an ADL self-care performance deficit with interventions of bathing and bed mobility require staff x1 for assistance and toileting required supervision as needed. Record review of POC Task Care Record for the month of April reflected the resident was to have bathing on Tuesday, Thursday, and Saturday, days. Resident # 66 with documented baths on 4/4/25, 4/8/25, and 4/10/25. Resident # 66 to have toilet use, personal hygiene, transferring, bed mobility, bowel continence, and ADL assistance documented each shift. Resident # 66 had no documentation for toilet use, personal hygiene, transferring, bed mobility, bowel continence, and ADL assistance on 4/5/25, 4/11/25, and 4/19/25. Record review of Resident # 66 progress notes for April and found no refusals documented. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/21/25 at 2:24 PM Resident # 66's RP stated she had concerns because at the time of Resident # 66's admission staff were unaware the resident had even admitted to the facility for the first 5 hours. The RP stated she came into the room and her husband was in the dark, so she turned the room light on, and a staff member came in and stated, I did not even know there was a resident in this room. The RP stated the facility was always greatly understaffed. When the resident eats in his room staff were not present to help even though the resident admitted due to aspiration pneumonia. The RP stated the MA told her that resident admitted on Thursday 4/3/25 and did not receive medication until Sunday 4/6/25 when the orders were filled. The RP stated last week she notified the ADM the resident was lying in bed and had not been changed for over 4 hours. The RP stated Therapy came to get the resident while the RP was present, and the resident was soaked in urine all the way up the back of his shirt. The RP stated when staff were here, they were good about helping and providing care, the problem was there was just many times there were no staff present. The RP stated the staffing issues were during the week and on the weekends. The RP stated the staff were frequently arguing in the hallway about the low staffing and job responsibilities. 7. Record review of the face sheet dated 4/22/25 for Resident # 72 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of quadriplegia (a paralysis that affects the ability to voluntarily move the upper and lower body), osteomyelitis (inflammation of the bone caused by infection), pressure ulcer of sacral region stage 4 (bedsores on the buttocks that involves full thickness skin and tissue loss), muscle weakness, anemia (lack of blood), lack of coordination, acute bronchitis (a short term inflammation of the lungs bronchial tubes), and anxiety disorder. Record review of the Quarterly MDS for Resident # 72 dated 3/7/25 reflected a BIMS score of 15 indicating intact cognitive status. Section GG - Functional Abilities reflected he was totally dependent for toileting, bathing, dressing, and transfers. Resident # 72 was substantial maximal assistance for personal hygiene. Record review of the Care Plan for Resident # 72 dated 12/31/24 reflected Resident # 72 had bowel incontinence with interventions of check resident every 2 hours and assist with toileting as needed. Provide perineal care after each incontinent episode. See care plan on mobility, ADL's, cognitive deficit, and communication. Resident # 72 had an ADL self-care deficit with interventions of bathing, bed mobility, toileting, and dressing of staff x2 for assistance. Resident # 72 required a lift for all transfers. Record review of POC Task Care Record for the month of April reflected the resident was to have bathing on Monday, Wednesday, and Fridays. Resident # 72 with documented baths on 4/3/25, 4/8/25, and 4/14/25. The resident was to have toilet use, personal hygiene, bowel continence, transferring, bed mobility, and ADL assistance documented each shift. Resident # 72 had no documentation for toilet use, personal hygiene, bowel continence, transferring, bed mobility, and ADL assistance on 4/1/25, 4/5/25, 4/6/25, 4/8/25, 4/11/25, and 4/19/25. Record review of Resident # 72 progress notes for April and found no refusals documented. (continued on next page)

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	04/23/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 4/21/25 at 3:45 PM with Resident # 72 revealed the resident was up in his motorized wheelchair outside in front of the building visiting with fellow residents. The resident had concerns about staffing and stated it had been a problem since the end of last year. The resident stated he had not gotten up on Friday the 18th, as nobody came to get him up until 3:00 pm, even though he had been asking all day to get up. The resident stated by that time he just told staff never mind as it was too late in the day. The resident stated he had not gotten up at all or offered to on Saturday the 19th and Sunday the 20th even though he had asked to be gotten up. The resident stated he was told by staff, I need another staff member to help me get you up and nobody is here. The resident stated his shower days were M, W, and F, in the evening. The resident stated he was supposed to get bed baths on these days. The resident stated he had not received a bath in a week. The resident stated the call response time was slow, and you must wait several hours before anyone came to see what was needed. 8. Record review of the face sheet dated 4/22/25 for Resident # 73 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of cerebral infarction (stroke), abnormalities of gait and mobility, lack of coordination, muscle weakness, atrial fibrillation (irregular often rapid heart rate), mild cognitive impairment, major depressive disorder (clinical depression), hemiplegia (muscle weakness or partial paralysis) affecting left non dominant side, bradycardia (slower than expected heart rate), insomnia (persistent problems falling and staying asleep), prostatic hyperplasia (prostate gland enlargement), and atherosclerosis (buildup of fats, cholesterol, and other substances in and on the artery walls) of coronary artery bypass graft. Record review of the Quarterly MDS for Resident # 73 dated 1/19/25 reflected a BIMS score of 12 indicating moderate cognitive impairment. Section GG - Functional Abilities reflected he required set up/ clean up assistance for bathing with supervision/touching assistance for bathing transfers. Record review of the Care Plan for Resident # 73 dated 11/12/24 reflected the resident had hemiplegia/hemiparesis related to stroke with interventions of assist with ADLs/mobility as needed. The resident had an ADL self-care performance deficit with interventions of bathing which required staff x1 assistance, toileting, transfers, and bed mobility supervision as needed. Record review of Resident # 73 progress notes for April and found no refusals documented. In an interview on 4/21/25 at 11:22 AM Resident # 73 stated the facility was behind on showers. The resident stated he last had a shower on Saturday 4/19/25 but he took himself to the shower room. The resident stated prior to the 19th, his last shower was on Tuesday 4/15/25. The resident stated the call response time was slow waiting at least 1 hour on staff and they don't come at all. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/23/25 at 10:14 AM Resident # 73's RP stated she took the resident out of the facility to attend a wedding and they returned to the facility between 10:30 PM-11:30 PM. The RP stated when they entered the parking lot, she noticed there were only 3 cars in the lot. The RP stated she walked Resident # 73 back into the facility and encountered no staff during her time at the facility. The RP stated there may have been 1 person there, but she didn't recall seeing or speaking to anyone. The RP stated she had many concerns with staffing and had brought this to the attention of staff in the form of 10 but less than 20 complaints at most made to the former ADM, but her latest complaint was this week, and it was related to this past Easter weekend. The RP stated she typically took Resident # 73 to church on Saturday night but last week they went on Sunday since it was Easter. The RP stated Resident # 73 was supposed to get a bath on Saturday, so the RP stated she called the facility 2x last week to remind staff Resident # 73 needed a bath on Saturday for church on Sunday. The RP stated staff assured her this would occur. The RP stated Resident # 73 did not get a bath on Saturday. The RP stated she met with the interim ADM and the new ADM on Monday about the shower issue again. The RP was assured it would be dealt with and the resident would receive a shower. The RP stated Resident # 73 still had not received a bath and it had been at least 8 days since the last bath. The RP stated when she had complained in the past the ADM would tell her the facility was working on the issue but there was never any resolution given. The RP stated there was high staff turnover at the facility, it was basically a revolving door, and she was unsure of what the staffing issue truly was. The RP stated the facility didn't follow up or through with resolutions to problems. 9. Record review of Resident #76 's undated face sheet reflected he was [AGE] years old, admitted on [DATE], and had a diagnosis of type 2 diabetes. Record review of Resident # 76 's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognitive response. Section GG- Functional Abilities reflected Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance. Resident #76 required one-person physical assist. Review of a task schedule dated April 2025 for Resident #76 reflected she was to have showers on Tuesday, Thursday, and Saturday, day shift. He had documented baths on Saturday April 5th, Thursday April 10th,, and Saturday April 19th. Record review of Resident # 76 progress notes for April and found no refusals documented. In an interview on 04/21/25 at 11:33 AM Resident #76 stated he did not want to complain but he had his first shower since his admission [DATE]) the day before Easter (04/19/2025). He stated there was not enough staff to help him with a shower because he required two staff assist and he was transferred by a mechanical lift. He stated sometimes the staff would give him a bed bathe because it was easier for them. An observation and interview on 04/23/25 at 11:18 AM, Resident # 76 was laying in his bed listening to music on his phone. He stated he was supposed to get a shower last night (04/22/25) and he did not. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/25 at 2:16 PM CNA F stated some of the resident's showers were scheduled for the mornings and some residents' showers were scheduled for the evenings. She stated she had not given showers to anyone besides one resident because she had an accident and needed a shower. She stated she thought an aide was assigned to shower assignments in the evenings, but she was not sure if showers were given. CNA F stated, to be honest I have not given a lot of showers and there is not enough of staff to help. I do not know how to document showers and I do not know who my supervisor is to ask for help. This failure could affect the residents by residents not receiving the care they required in a timely manner. In an interview on 04/22/2025 at 02:25PM CNA G stated she had only worked for 2 days and was on the job training. She stated she had not been trained on hall 200 and was assigned to 400 hall. She stated she thought there was a shower tech who came in the morning, but she had not seen any one take showers since she started this week. This failure could affect residents by the residents not receiving the care they required in a timely manner. In an interview on 4/23/25 at 10:43 AM with MR/CS/CNA C revealed MR/CS/CNA C stated Sometimes we have a problem with staffing on the weekends. The staff don't call in and they don't show up. MR/CS/CNA C stated when this happens sometimes it can affect the residents by meaning the care they need is delayed. In an interview on 04/23/2025 at 10:58 AM CNA K stated they have been told to find another staff on another hall when they need help with showers and when they need to get a Resident who required a 2 person assist for showers and mobility transfers. She stated she was not sure if Resident # 15 had a shower because he required a mechanical lift and the majority if the time the battery was not charged. She stated she would guess the CNAs were responsible for ensuring the mechanical lifts were charged but no one had ever told her who was responsible. She stated showers should be documented in the POC and if a resident should get a bed bathe it would be in the POC. She stated she did not believe showers were given as scheduled because they were always short on staff and people call in a lot. CNA K stated if the facility is short staffed then sometimes the resident care is delayed. CNA K stated the administration has been made aware of the staffing problems and always respond we are working on it. In an interview on 4/23/25 at 10:59 AM CNA L stated staffing of CNAs and nurses had been poor since January. CNA L states it was supposed to be 2 CNAs on each hall but frequently it was just one CNA for each hall. CNA L stated 100 and 400 halls were heavy on the workload of residents that needed more assistance, or 2 persons assist. CNA L stated the day shift, and the weekends were when the staff shortages were the worst. CNA L stated the evening and night shift were fully staffed. CNA L stated when there was only 1 CNA per hall, and a resident was a two person assist needed help or to be transferred, she would ask for help from one of the other CNA's and they tag team and help each other out. CNA L stated she must tell that resident it will be a little bit before she could help them as she must get some assistance. CNA L stated if she requested help from another CNA on a different hall then she would go and help them with their residents that required 2 people assist. CNA L stated sometimes residents must wait for assistance if they were short staffed which would be a delay in care for residents. CNA L stated upper management had been told of the short staffing and always respond we are aware and are working on the matter. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/23/25 at 11:34 AM CNA M stated staffing was not good. CNA M stated the staff were always short and it had been this way since she started 7 months ago. The leadership was the problem. She stated, I have worked in the field for the past 14 years and some facility leadership does not care about letting the staff struggle. CNA M stated she went PRN a month ago because of staffing problems and was always working so short. CNA M stated most of the time there was only 1 CNA per hall even if the schedule said there would be 2. CNA M stated the schedule was written as to where it appeared the building was fully staffed. CNA M stated sometimes resident care and assistance is delayed while hunting for staff members to assist if the resident requires a two person assist. CNA M stated administration is aware of the staffing problem but does not care and just says they are working on the issue. In an interview on 4/23/25 at 1:53 PM the RN stated if CNAs can't give showers as scheduled then the CNA was supposed to let the charge nurse know so the shower could be attempted or be rescheduled. The RN stated the shortage of staff contributed to the lack of shower/baths and overall ADL care that could not be provided. The RN stated the ADLs were documented in the facility electronic record keeping system by the CNAs. The RN stated the facility used to have a shower book with the resident's shower schedule at the nurse's station, but she was unsure if that was still being utilized. In an interview on 4/23/25 at 2:22 PM RCN stated the facility always had enough staff to complete ADL tasks and low staffing was not a reason for ADL tasks not to be completed for the residents. RCN stated it was their expectation the staff member explained to the resident the care being provided and communicate with the residents in a professional manner. RCN stated if the resident was not communicated with about their care, then the residents could become frightened and unsure of what was being done with their care. RCN stated staff should be ensuring baths/showers and ADL care were completed and the nurse should be going to ask the resident about ADL care and if they still refused, the MD and the RP should be notified of refusal. RCN stated if a resident refuse it should be documented in the electronic record keeping system. In an interview on 04/23/25 at 2:37 PM the RN stated,[TRUNCATED]

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to post the daily nurse staffing data at the beginning of each shift in a prominent place, readily accessible to residents and visitors that included the facility name; and the total number of hours worked per shift by the registered nurses, the licensed vocational nurses, and the certified nurse aides directly responsible for resident care for the facility for 1 of 1 days reviewed for staffing postings. The facility failed to post current daily staffing information on 04/22/2025. This failure could place the residents, families, and visitors at risk of not having access to information regarding the number of staff working each day to provide care on all shifts. Findings included: In an interview and observation on 04/22/25 at 5:00 PM the ADM stated and showed the state surveyor an empty plastic notice holder outside the DON office, was where the staff posting should be located. In an interview on 04/22/2025 at 5:02 PM, the DON stated staffing should be posted because it told visitors how many staff [NAME] in the building. In an interview on 04/23/2025 at 9:40 AM the ADON stated putting up the staff posting was something she had forgotten to do as she had been working as a floor nurse as well. She stated it should have been posted by her so everyone would know how many staff were working. In an interview on 04/23/2025 at 1:17 PM the ADM stated her expectation was for staff to post the daily staffing. She further stated it was important for staff and family members to know how many staff were in the building. A policy and procedure regarding staff postings were requested from the ADM on 04/23/2025 at 10:00 AM. In an interview on 04/23/2025 at 1:30 PM the ADM stated the facility did not have a policy regarding daily nurse staffing data.

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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. Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication room reviewed for pharmacy services. The facility failed to ensure an expired medication was removed from the medication storage room. This failure could place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose and possible exacerbation of health conditions. Findings included: Observation on 04/21/2025 at 3:50 PM in the medication storage room across from the nurse stations revealed a bottle of Glucosamine and Chondroitin with an expiration date of 3/2025. In an interview on 04/21/2025 at 4:03 PM the RCN stated expired medications could potentially not be as effective and could lead to harm In an interview on 04/23/2025 at 10:38 AM the MR/CS/CNA C stated she had worked for the company for almost seven years and had been at the facility since October of 2024. She stated she was responsible for removing expired medications from the medication storage room. She stated she performed a monthly audit of the medications but sometimes she might miss removing one. She stated if a medication was expired it should be disposed of. She stated if the expired medication was given to a resident they could have a harmful reaction. In an interview on 04/23/2025 at 1:10 PM the ADM stated nursing staff should check medications for an expiration date prior to administering it to a resident. She stated if the medication was expired it should be discarded and replaced. She stated the expired medication would not be as effective. In an interview on 04/23/2025 at 10:50 AM the DON stated MR/CS/CNA C audited the medication storage room. She stated medications could be ineffective if they were expired. In an interview on 04/23/2025 at 10:30 AM the ADM stated there was no specific policy and procedure regarding expired medications.

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	04/23/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the drug regimen review recommendations from the pharmacy consultant were received and acted upon for 1 (Resident # 58) of 4 residents reviewed for drug regimen review. The facility failed to follow up on pharmacy consultant recommendations dated 1/28/25 for Resident # 58. These failures could place residents being at risk for medication errors, unnecessary medications, and incorrect administration. Findings included: Record review of admission a face sheet dated 4/23/25 for Resident # 58 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy), atrial fibrillation (irregular heart rate), cognitive communication deficit (difficulties in communication caused by problems with cognitive functions such as attention, memory, and problem solving), hyperlipidemia (increased fat particle in the blood), chronic pain, muscle weakness, hallucinations, amnesia, hypertension (high blood pressure), major depressive disorder (clinical depression), hypothyroidism (underactive thyroid gland), Parkinson's disease with dyskinesia (a situation where individuals with Parkinson's a central nervous system disorder that affects movement experience abnormal involuntary movements), congestive heart failure (a condition where the heart is unable to pump blood effectively to the organs), cerebral infarction (stroke), lack of coordination, and nontraumatic subarachnoid hemorrhage (brain bleed). Record review of a Quarterly MDS dated [DATE] for Resident # 58 reflected a BIMS score of 13 indicating intact borderline cognition. Section GG Functional Abilities reflected Resident # 58 required supervision or touching assistance for all ADLs. Record review of a Care Plan dated 9/9/24 reflected Resident # 58 required anti-psychotic medications with interventions of administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, the MD to consider dosage reduction when clinically appropriate. Discuss with the MD and family ongoing need for use of the medication. Educate the resident/family /caregivers about risks, benefits, and the side effects. Monitor/record occurrence of for target behavior symptoms and document per facility protocol. Monitor/record/report to the MD prn side effects and adverse reactions of psychoactive medications. Record review of clinical physician orders dated 4/9/25 for Quetiapine 50 mg 1 tablet orally at bedtime. Record review of April MAR reflected Quetiapine 50 mg 1 tablet orally at bedtime. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 58 progress notes for April reflected no physician notification seen or documented. Record review of pharmacy recommendations dated 1/28/25 reflected for Resident # 58 a gradual dose reduction request for Quetiapine 12.5 mg PO HS. In an interview on 4/21/25 at 2:00 PM with Resident # 58 revealed the resident sitting in her chair in her room. The resident neatly groomed. The resident had concerns with low staffing and staff constantly changing. The resident stated the call response was not good, as the aides just come turn the light off and don't even ask what their need was. The resident stated she had frequent pain and needed more assistance with daily tasks because of the pain. In an interview on 4/22/25 at 5:05 PM. RCN stated she was unable to provide documentation that the pharmacy recommendations dated 1/28/25 concerning the GDR for Resident #58 had been sent to the physician for review. The RCN stated there had been some discrepancy with getting pharmacy recommendations uploaded to the physician for review due to the facility DON and Medical Records staff having staff turnover. The RCN stated corporate staff had been in the building assisting and training the new staff in hopes to correct the problems. The RCN stated it was the responsibility of the DON to ensure pharmacy recommendations were communicated to the physician. The RCN stated it could negatively affect residents if the pharmacy recommendations were not communicated to the physician. In an interview on 4/23/25 at 3:19 PM The ADM stated she was unaware the pharmacy recommendations for Resident # 58 had not been communicated to the physician. The ADM stated not having pharmacy recommendations communicated to the physician could negatively affect residents by overmedication, undermedication, and/or duplicate medication. The ADM stated the DON was responsible for ensuring the pharmacy recommendations were communicated to the physician. Record review of Psychotropic Drug policy dated 2003 revision on 10/25/17 reflected The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, the facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic The facility must will ensure that- 1. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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	745051	A. Building B. Wing	04/23/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to properly store, label, and/or secure medications and biologicals for 1 of 2 medication carts. The facility failed to ensure the medication aide cart for A hall was locked when unattended by CMA J on [DATE] from 07:15 AM until 07:43 AM. These failures could place residents at risk of harm due to unauthorized access and potential ingestion of medication, needles, and other biologicals. These failures could also place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose and possible exacerbation of health conditions. Findings included: Observations on [DATE] from 7:15 AM until 7:43 AM revealed a medication cart on A Hall intermittently left unlocked, facing the hallway, and unattended by CMA J as she went into rooms and dispensed medications to the residents on the hall. In an interview on [DATE] at 12:06 PM CMA J stated she was a prn employee who had not worked at the facility for one month. She stated [DATE] was the third time she had passed medications by herself without supervision. She stated by leaving the medication cart unlocked a resident could get into the medications, ingest them, overdose or could have an allergic reaction and have to go to the hospital. She stated she had been trained to lock the medication cart. In an interview on [DATE] at 9:50 AM the ADON stated the medication carts should be locked anytime the nurse or MA [NAME] not at the cart. She stated a resident could access the cart, ingest a medication, and become very ill. She stated there would be no way of knowing what the resident ingested. In an interview on [DATE] at 10:50 AM the DON stated the medication cart should always be locked when the nurse or MA stepped away from it. She stated if the medication cart was unlocked it would be accessible to residents, visitors, and staff. She stated if they ingested medications the person could have an allergic reaction depending on the medications and possibly need to be hospitalized . In an interview on [DATE] at 1:12 PM the ADM stated she expected the medication cart to be locked when it was not being attended. She stated the medication could be taken and if ingested could cause an adverse reaction. (continued on next page)

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Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Pharmacy Policy and Procedure Manual dated 2003 revised [DATE] and titled Medication Administration Procedures reflected 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used. Check marks are not acceptable. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse. 8. After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured.

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	04/23/2025

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Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to discard a ham expired 04/16/2025 containing ice particles in the plastic ziplog bag. 2. The facility failed to ensure an opened bag of rolls were properly sealed, labeled, and dated. These failures could place residents at risk for food borne illness. The findings included: Observation on 04/ 21/2025 at 9:00 AM revealed a ham which was not in the original packing and stored in a freezer bag with an expiration date of 04/16/2025 and filled with ice particles. Observation on 04/21/2025 at 9:00Am revealed a 24-count package of rolls in the freezer, unsealed, and not labeled. An interview on 04/22/25 at 03:06 PM the DM stated she was not aware of expired ham and rolls that were opened and not labeled in freezer or she would have thrown it in the trash. She stated it was every kitchen staff's responsibility to ensure all food items [NAME] dated and expired food items were discarded. She stated kitchen staff were to date and label food when the food truck came in weekly. She stated there could be a potential risk of the residents getting sick if they [NAME] served expired food. In an interview on 4/23/2024 at 10:16AM with CK , she stated she worked in the kitchen for 5 months. She stated she was trained by the DM to check the refrigerator and the freezer daily or every other day and throw away expired and unlabeled food items. She stated if expired food was not discarded a resident could get sick. In an interview on 04/23/25 at 2:59 AM the ADM stated her expectations were for all kitchen staff to ensure foods were labeled and/ dated once they come off the truck and any open food items were to be labeled and dated . She stated they should monitor for expired food daily and discard it if it was expired. She stated there was a potential for someone to get sick and the food could be spoiled if given to the residents if expired or not dated. Record review of facility Food Storage and Supplies dated ,unknown month , 2012, If perishable food items are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated and food becomes spoiled and should not be served. Food items such as loaves of bread or dairy products with a stamped best-by or use by date do not need to be labeled when opened as this will not affect the date by which they should be used. However, if possible, food spoilage is observed prior to the best by date, the product will be discarded. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under § 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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	745051	A. Building B. Wing	04/23/2025

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Five Points Nursing & Rehabilitation of College St	3105 Corsair Drive College Station, TX 77845

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for fiscal year 2025 for the first quarter (October 1, 2024, to December 31, 2024) reviewed for one of one facility administration reviewed. The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for October 1, 2024, to December 31, 2024. This failure could place all residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings Included: Record review of the CMS PBJ report for CMS FY Quarter 1 2025 (October 1, 2024-December 31, 2024) indicated the facility failed to submit data for the quarter. In an interview on 4/21/25 at 9:49 AM with ADM and RCN revealed ADM and RCN stated that they were aware the PBJ data had not been submitted for the prior quarter to CMS. ADM stated she was unsure as to why the data had not been reported and she would reach out to her corporate level staff and attempt to get an answer. In an interview on 4/23/25 at 3:19 PM with ADM revealed the ADM was still unsure as to why the PBJ data had not been submitted to CMS. ADM stated she did not think it had the potential to negatively affect the residents by not submitting the data. ADM stated it was the responsibility of the corporate office to ensure the PBJ data was submitted to CMS in the required timeframes. ADM stated she was still waiting for responses from some corporate staff concerning the PBJ submission and she would let the surveyor know when she got a response. ADM stated she was unsure if the facility had a policy on PBJ data reporting, but she would check. In an interview on 4/23/25 at 4:45 PM with the ADM revealed the ADM stated she had been told from the RCN that the facility had not submitted their PBJ data to CMS because the company had just received their federal number from CMS in mid-October and their next scheduled reporting date had not occurred since they had received the number. ADM stated that the response from the RCN is the only response she had received concerning the lack of PBJ data submission. Record review of PBJ data submission policy attempted/ requested from ADM on 4/23/25 at 3:19 PM. The policy was not provided prior to exit.

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	745051	A. Building B. Wing	04/23/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #13) of 15 residents reviewed for infection control. The facility failed to ensure TN, MDSC B, DON performed appropriate Enhanced Barrier Precaution steps while providing wound care to Resident #13. This deficient practice could place residents in the facility at risk for infections that could lead to other facility-acquired infections, delayed wound healing, sepsis, and hospitalizations. Findings included: Record review of the undated Face Sheet for Resident #13 reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis (disease in which the immune system eats away at the protective covering of nerves), and pressure induced deep tissue damage of other site. Record review of the Optional State Assessment MDS for Resident #13 dated 04/15/2025 reflected he had a BIMS score of 10 indicating moderate cognitive impairment. Section M - Skin Conditions reflected he had one or more unhealed pressure ulcers/injuries and had two Stage 4 pressure ulcers (most severe stage involving full-thickness skin and tissue loss extending to muscle, tendon or bone.) Record review of the Care Plan for Resident #13 dated 11/22/2024 reflected Focus: Resident is on enhanced barrier precautions. Goal: There will not be any transmission of infection from or to the resident. Interventions: Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Posting at the resident's room entrance indicating the resident is on enhanced barrier precautions. Record review of the order Summary Report dated 4/22/2025 for Resident #13 indicated he had two stage 4 pressure ulcers, an indwelling catheter and orders for enhanced barrier precautions in place. Observation on 04/22/2025 at 9:30 AM of the door to Resident #13's room revealed two posted signs. The first sign revealed Stop Enhanced Barrier Precautions. Everyone must clean their hands including before entering and when leaving room. Providers and staff must also wear gloves and a gown for the following High-Contact resident care activities, Wound care: any skin opening requiring a dressing. The second sign revealed Multidrug-resistant organisms (MDROs) are a threat to our residents. Enhanced Barrier Precaution (EBP) steps Perform hand hygiene, wear gown, wear gloves. Use EBP during high-contact care activities for residents with 1. Indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) 2. Wounds 3. Colonization or infection with an MDRO. (continued on next page)

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	745051	A. Building B. Wing	04/23/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/22/2025 at 9:30 AM of the TN preparing to provide wound care for Resident #13 and assisted by MDSC B and the DON. The TN cleaned the bedside tray with germicidal disinfectant wipes, assembled the wound care supplies on wax paper including silver alginate, a border dressing, normal saline and 4 X 4 gauze. She prepared a bleach-based solution and cleaned her scissors with germicidal disinfectant wipes. The three staff entered the room without donning gowns. MDSC B was not gowned and pulled the resident's blanket down thereby contaminating her scrubs. TN was not gowned and removed the dressing to the resident's left elbow. MDSC B was not wearing a gown and held his elbow up so that wound care could be performed. TN removed her gloves and sanitized her hands. Observation on 04/22/2025 at 9:39 AM of the DON and MDSC B who did not have protective gowns on revealed they turned Resident #13 onto his right side and their uniforms touched his bedding and gown. The resident had had a bowel movement, and the TN cleaned the resident's buttocks while leaning over and touching his bedding with her uniform. She changed his brief, removed her gloves, sanitized her hands and re-gloved. All three staff rolled him to his left side. Their uniforms were touching his bedding and his gown. The DON removed the soiled brief, washed her hands and re-gloved. At 9:45 AM MDSC B touched the curtain between the residents with a soiled glove. TN washed her hands and retrieved more gloves from the cart in the hallway. TN returned to the room still without a gown on. MDSC B and the DON turned the resident to his right side touching his gown and bedding with their uniforms. TN removed the under pad and placed another clean pad underneath him. TN removed the soiled dressing from his left buttock, cleaned her hands with sanitizer and re-gloved. TN cleaned his wound with NS and 4 X 4 gauze. At 9:54 AM, the TN leaned on the resident's bed to look at his wound and contaminated her uniform. TN then applied a dressing to the wound. In an interview on 04/22/2025 at 10:00 AM MDSC B stated all three staff who were in the room during wound care for Resident #13 should have been wearing gowns because the resident was on EBP. She stated by not wearing a gown they could have transmitted bacteria to other residents and cause cross contamination. In an interview on 04/22/2025 at 10:05 AM the TN stated she started working at the facility in April of 2024. She stated she had been a Charge Nurse, ADON, then Charge Nurse again and was now the wound care nurse since 03/19/2025. She stated she had been a nurse for 16 years. She stated she had received mostly on the job training for wound care, but she did get her WCC on 04/21/2025. She stated she should have put a gown on to prevent soiling her clothing, and by not doing so it could cause cross contamination between residents. She stated he had an indwelling catheter and other residents could get the same infection he had. She could not specify what if any infection he had. In an interview on 4/22/2025 at 10:09 AM the DON stated all the staff involved in performing the wound care for Resident #13 should have worn gowns to prevent the spread of infection from the staff to the resident and from the resident to the staff. She stated her uniform could have picked up his bodily fluids. She stated he could have had transmissible infections that have been spread around the facility. She stated she had been in-serviced on infection control and had EBP training. In an interview on 04/23/2025 at 1:15 PM the ADM stated nursing staff attending to a resident on EBP would follow the policy and procedure and wear a gown. She stated by not wearing a gown there was an increased risk of spreading infection. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Infection Control Policy and Procedure Manual dated 2019 reflected Fundamentals of Infection Control Precautions: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures. Gowns that are selected for use in the facility will be impermeable to liquids. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environments; when gowns are worn for this purpose, they are removed before the personnel leave the resident's environment. Record review of an Enhanced Barrier Precautions Policy and Procedure dated 04/01/2024 reflected, Enhanced Barrier Precautions Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3); or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.