STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676245	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Nursing and Rehabilitation Center	104 Rex Kerwin Court Pflugerville, TX 78660

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 24 hours if the events that cause the allegation involve abuse and do not result in serious bodily injury for 1 of 3 residents (Resident #1) reviewed for abuse and neglect, in that: The facility failed to ensure that the DON reported allegations of abuse immediately, but no later than 2 hours to the ADM when Resident #1 reported she gave me a bruise to the DON on 06/12/2025. This failure could result in continued abuse or neglect of residents, injury, and/or psychosocial harm. Findings include: Review of Resident #1 face sheet reflected a year-old female admitted on [DATE] with diagnoses of major depressive disorder (serious mental illness characterized by sadness, loss of interest in activities and other symptoms that interfere with daily life), anxiety disorder (persistent worry and fear that can interfere with daily life), and impulse disorder (group of conditions where individuals struggles to resist strong urges or impulses leading to behaviors that can be harmful to themselves or others. Review of Resident #1's care plan dated 05/23/2021 reflected Resident #1 was at risk for skin impairment related to impaired cognition, anemia, impaired mobility and obesity. Interventions included to conduct skin inspections/examinations weekly and as needed. Review of Resident #1's care plan dated 11/28/2022 reflected Resident #1 was resistive to care and refused shower and hygiene at times. Interventions included to allow resident to make decisions about treatment regimen to provide sense of control and educate about possible outcome of non-compliance. Review of Resident #1's care plan dated 06/18/2025 reflected Resident #1 has potential to be physically aggressive with attempts to throw items at staff and punch staff. Interventions included that 2 staff members were present during showers. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1 quarterly MDS dated [DATE] reflected BIMS of 13 which indicated no cognitive impairment. Further review reflected Resident #1 had no physical symptoms directed towards others 7 days prior to assessment. Review of progress note dated 06/13/2025 at 2:48 PM reflected Resident #1 had hematoma on right forearm. Resident #1 reported she noticed after her shower the other day. NP was notified with no new orders made at that time. Review of progress note dated 06/17/2025 at 6:35 PM by RN B reflected call was received by RP for Resident #1, RP indicated Resident #1 reported she was pinched on her arm by CNA last week and wanted to report to the ADM. RN B wrote that reddish discoloration was noted to right forearm and redness noted under both breasts. NP notified. During an interview on 06/25/2025 at 10:43 AM, Resident #1 stated around 9:00 AM last week she had a shower and CNA C grabbed Resident #1's left arm and then pinched her right arm. Resident #1 stated this occurred about two weeks ago. Resident #1 stated about a week after the incident the ADM spoke with her about it and told Resident #1 this is the first I'm hearing about this. Resident #1 stated a day after the incident she reported to RN A and cannot recall if she reported it to anyone else. Resident #1 stated she spoke with her RP and her RP reported it to the ADM. Resident #1 stated she has not worked with CNA C since the incident and that she felt safe at the facility. Resident #1 stated her shower days are Monday, Wednesday and Friday and the shower occurred on a non-scheduled shower day. Observation on 06/25/2025 at 10:47 PM, revealed two small faded red marks about an inch apart on Resident #1's right forearm. The marks were not perfectly circular and had no coherent shape. Resident #1 stated that one spot (closer to elbow) happened about five days after the other and the other spot (closer to wrist) was from some other time. Resident #1 reported that the bruise from when CNA C pinched her was gone as of 06/25/2025. During an interview on 06/25/2025 at 12:55 PM, RN A stated she saw a mark on Resident #1's right arm a few weeks ago. RN A stated she asked Resident #1 what happened to her forearm and Resident #1 reported I got it from my shower yesterday. RN A stated Resident #1 reported oh it's nothing I just got this from the shower yesterday. RN A stated the mark was about the size of a penny and it was dark red and not purple. RN A stated Resident #1 did not report that anyone pinched her or any allegations of abuse. RN A stated she completed a head to toe assessment with Resident #1. RN A stated Resident #1 has fragile skin. RN A stated if Resident #1 reported that someone had pinched or held her down she would report that to the administrator as soon as the incident was discovered. RN A stated the ADM was the abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 at 1:16 PM, CNA D reported that she normally worked on Resident #1's hall. CNA D stated she worked on 06/13/2025 on Resident #1's hall. CNA D stated she does not usually work directly with Resident #1 as Resident #1 wasparticular and she usually just passes the breakfast and lunch trays to Resident #1. CNA D stated she waited until Resident #1 left her room to make up the bed and stated on 06/13/2025 Resident #1 asked CNA D to move some furniture or items in her room to a certain spot. CNA D stated Resident #1 refused her showers often and Resident #1 rarely showered. CNA D stated she tried to encourage Resident #1 to take a shower but Resident #1 usually said she did not want to. CNA D stated she did not provide a shower to Resident #1 on 06/13/2025. CNA D stated Resident #1 did not express any concerns on 06/13/2025 and Resident #1 did not report any abuse to CNA D. CNA D stated she checked all residents skin in the morning during her rounds and she did not notice any changes or issues in Resident #1's skin on 06/13/2025. CNA D stated any complaints regarding abuse should be reported to the ADM and nurse immediately. CNA D stated the abuse coordinator was the ADM. During an interview on 06/25/2025 at 1:32 PM, CNA C stated she assisted Resident #1 with her shower a few weeks ago but could not recall the exact day. CNA C stated CNA E also was present during the shower and when CNA C interacted with Resident #1. CNA C stated she gave Resident #1 a shower and CNA C stated she washed Resident #1's back for her, back of her legs and feet. CNA C stated Resident #1 washed the front of her upper body and her hair. CNA C stated she put shampoo and conditioner in Resident #1's hair but Resident #1 washed it herself. CNA C stated it was in the morning when she showered Resident #1. CNA C stated she did not hold Resident #1's arms down or pinch Resident #1. CNA C stated Resident #1 sprayed CNA C with the shower head. CNA C stated she did not spray Resident #1 with the shower head. CNA C stated her uniform was wet from the shower and she had to stand outside after to dry. CNA C stated she noticed green discoloration on Resident #1's neck from her jewelry that washed off. CNA C stated she had received in-services over abuse and neglect and any reports of abuse should be reported to the ADM within two hours. CNA C stated the ADM was the abuse coordinator. CNA C stated the ADM suspended her on 06/17/2025 after an allegation was reported from Resident #1. During an interview on 06/25/2025 at 1:41 PM, CNA E stated she and CNA C assisted Resident #1 to the shower. CNA E stated she sat on a bench in the shower room and only observed the shower and CNA C assisted Resident #1 during the shower. CNA E stated that CNA C washed Resident #1's back, hair, legs and put soap on a towel so Resident #1 could wash herself. CNA E stated Resident #1 sprayed CNA C with water. CNA E stated CNA C rinsed Resident #1's hair, back and legs and did not spray Resident #1 in the face. CNA E stated CNA C did not pinch or hold down Resident #1's arm during the shower. CNA E stated Resident #1's skin appeared at baseline during the shower. CNA E stated Resident #1 did not report any allegations of abuse nor that any one pinched her the remainder of the shift or since the shower. CNA E stated she was made aware of the allegation about a week later and was asked to write a statement. CNA E stated she received in-services on abuse and neglect and she had to report abuse to the abuse coordinator which was the ADM. During an interview on 06/25/2025 at 1:55 PM, the DON stated she checked in with Resident #1 after her shower and thanked Resident #1 for taking a shower. The DON stated Resident #1 stated look at this bruise she did it. The DON stated she did not observe any bruising on the resident and that Resident #1 wheeled off and said whatever. The DON stated this was after the shower and was between 10:30 - 11:00 am. The DON stated when Resident #1 stated look at this bruise Resident #1 did not report any names. The DON did not report this to the ADM and stated she thought he heard it as it was after morning meeting when the IDT was leaving the conference room. The DON stated it was reported to her about a week later by the ADM that there was an allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2025 at 2:16 PM, RN B stated she worked on Resident #1's hall on 06/17/2025. RN B stated she received a call from Resident #1's RP that Resident #1 reported someone pinched her. RN B stated she immediately reported to the ADM. RN B stated there were two spots, and they were about the size of a coin. RN B stated they were red, they were not blue or yellow and looked newer. RN B stated they appeared to look as if they occurred the night or day before. RN B stated the spots were close together. RN B stated she worked on Resident#1's hall on 06/14/2025 and that there were no skin alterations or impairments noted then. RN B stated she completed a head-to-toe assessment on 06/17/2025 and no other impairments were noted. RN B stated any suspicions of abuse would be reported to the ADM immediately. RN B stated that Resident #1 reported that a CNA pinched her about a week ago when asked during the head-to-toe assessment. During an interview on 06/25/2025 at 4:07 PM, the ADM stated he was made aware of the allegation of abuse on 06/17/2025 after he spoke with Resident #1's RP. The ADM stated RN B reported the allegation to him and he contacted Resident #1's RP. The ADM stated that it was reported that Resident #1 had a bruise on her arm and that she was pinched by a CNA. The ADM stated the CNA was identified as CNA C and she was immediately suspended after he spoke with Resident #1. The ADM stated she interviewed Resident #1, CNA C and CNA E and found the allegation was unconfirmed due to witnessed being present during Resident #1's shower. The ADM stated he did not observe or talk with Resident #1 after her shower. The ADM stated that usually Resident #1 reported any concerns to him and he spoke with her almost daily and she did not mention any allegations of abuse. The ADM stated if a resident reported to any staff that someone gave them a bruise, he expected it be reported to him immediately. The ADM stated he was not aware that Resident #1 reported to the DON that someone gave her bruise after her shower. The ADM stated if he was made aware he would have changed his course of action in that the investigation would have started at that point. During an interview on 06/25/2025 at 4:27 PM, the DON stated when an allegation of abuse or neglect was reported, it should be reported immediately. The DON stated depending on the type of abuse, a delay in reporting could allow for ongoing abuse. Review of PIR dated 06/19/2025 reflected on 06/17/2025 at 6:35 PM, RN received a call from Resident #1's RP that Resident #1 was pinched on her arm by CNA last week. Further review of PIR reflected On 06/12/2025 CNAs informed the DON that [Resident #1] had an unpleasant odor. Resident #1 was asked to shower by the DON due to her history of refusing. Further review reflected After the shower [Resident #1] was noted at the smoking area upset. The DON stated Thank you for taking the shower. Resident stated 'Look at this bruise, she did it'. PIR reviewed the DON saw no bruising on Resident #1's arms. Review of statement by the DON dated 06/18/2025 reflected the DON thanked Resident #1 for taking a shower and Resident #1 started look at this bruise, she did it. The DON wrote that she looked at both of Resident #1's arms and no bruising was noted. Review of in-service dated 06/18/2025 reflected in-service was conducted with all staff over topic of Abuse, Neglect, Exploitation, which facility policy titled Abuse, Neglect, and Exploitation was reviewed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy dated 08/15/2022 and titled Abuse, Neglect, and Exploitation reflected under reporting and response that reporting of all alleged violations to the Administrator was required immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involved abuse or result in serious bodily injury. Further review reflected the facility will make all efforts to protect residents from physical and psychosocial harm, as well as additional abuse and included responding immediately to protect the alleged victim.