STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 of 2 residents (Resident #1) reviewed for abuse. The facility failed to thoroughly investigate an allegation of abuse reported to the Administrator regarding Resident #1 on 08/25/25. The Administrator did not interview Resident #1, her representative, or the caregiver that verbalized the allegation of abuse. These failures could place residents at risk for abuse, neglect, exploitation, mistreatment, and injuries of unknown source.Findings included: Record review of Resident #1's face sheet indicated she was a [AGE] year-old female, admitted to the facility on [DATE], and discharged on 08/25/25. Her diagnoses included dementia (a general term for a decline in mental ability that affects memory, thinking, and social skills to the point of interfering with daily life). Record review of the facility's Provider Investigation Report, dated 09/02/25, reflected: .Resident Profile[Resident #1] is a [AGE] year-old female who was admitted to the skilled unit on August 21, 2025. She has a BIMS of 10 [Moderately Impaired Cognition]. She has impaired cognition function/dementia or impaired thought processes.[Resident #1] has a deficit in self-care activities of daily living., as well as communication difficulties.Additionally she has a sitter to be with her.Description of the Allegation:On August 25, 2025, [Resident #1] was discharged from the facility at the request of her family. On the day of discharge, EMS was on-site to assist with [Resident #1's] transportation home. during this time, Resident #1's sitter was overheard telling EMS personnel that [Resident #1] had been abused and that hospice staff were aware.Provider Response:Upon receiving the verbal allegation of abuse on August 25, 2025, the facility immediately followed internal reporting protocols. The allegation was promptly communicated to the Charge Nurse.and escalated to the Administrator.However, no further protective actions or assessment were taken by the facility because the resident's family elected to discharge [Resident #1] from the facility.The facility conducted staff re-education focusing on Abuse and Neglect. The following individuals were also notified:* DON Notification* ADON Notification*[Corporate [NAME] President] Notification*MD/NP Notification*HHSC Notification.Investigation Summary:.Allegations of Abuse (August 25,2025):At approximately 6:45PM, CNA overheard the sitter telling EMS that [Resident #1] had been abused and that hospice staff were aware. The incident was reported to the charge nurse and administrator.Conclusion:The internal investigation into the abuse allegation revealed no witnesses or identified perpetrators. As a result, the facility concluded that the findings of the investigation were unconfirmed. No further incidents were reported following the resident's discharge.Provider action taken Post-Investigation:Continue staff education on facility policies to prevent and protect residents from all forms of Abuse and Neglect. During an interview on 09/09/25 at 9:54AM, the DON said she was the nurse who assessed the resident for discharge. She said she was not informed of any abuse allegation during her assessment. She said the resident and family were happy with everything that was done leading up to the discharge. She said the Administrator conducted the investigation into this incident. During an interview on 09/09/25 at 9:58AM, the Administrator said that on the evening of 08/25/25, he received a phone call reporting that a CNA had overheard Resident #1's sitter saying the resident had been abused in the facility. He said the resident had already left the building when he received the call. He said he did not investigate the allegation further because the resident had already left the building. He said he was unsure whether he had contact information for the sitter. He said he had been in Resident #1's room prior to discharge and no one had brought any concerns of abuse to his attention. He said Resident #1's family member was happy with Resident #1's care when he spoke with her prior to the abuse allegation. He said he did not speak with the family member about this allegation of abuse. He said he interviewed the CNA that overheard the conversation. He said he conducted safe surveys with the residents. During an interview on 09/09/25 at 10:26AM, ADON A said she was not present at the facility at the time of the abuse allegation involving Resident #1 on 08/25/25. She said she felt the Administrator should have talked to the family or the sitter regarding the abuse allegation to obtain more information. She said the risk was that abuse could be going on in the facility. During an interview on 09/09/25 at 10:31AM, the DON said she conducted a discharge assessment of Resident #1 and that neither the family nor the sitter reported any allegations of abuse. She said she did not feel like the caregiver should have been called because the family member and caregiver were together at the time of discharge. She said she had a conversation with the sitter on the day of discharge and she did not make an allegation of abuse to her. She said she tried to call the family member