STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2026
NAME OF PROVIDER OR SUPPLIER Longview Hill Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure treatment was provided, consistent with professional standards of practice, to prevent new pressure injuries from developing for 2 of 4 residents reviewed for pressure injuries (ulcers). (Resident #1, Resident #2)1. The facility failed to complete weekly skin assessments for Resident #1 since 01/27/26. 2. The facility failed to complete quarterly Braden Scale Assessments on Resident #1 and Resident #2. There were no quarterly Braden Scale Assessments for Resident #1 since 06/04/25 and for Resident #2 since 02/08/24.These failures could place residents at risk for developing avoidable pressure injuries and the worsening of existing pressure injuries.1. Record review of a face sheet dated 02/28/26 indicated Resident #1 was [AGE] years old and was initially admitted to the facility on [DATE] with diagnoses of heart failure, muscle weakness, and diabetes. The face sheet indicated Resident #1 had been discharged to an acute care hospital on [DATE]. There was no indication Resident #1 had been re-admitted to the facility.Record review of a quarterly MDS dated [DATE] indicated Resident #1 was understood and usually understood others. The MDS indicated a BIMS score of 02 which indicated severe cognitive impairment. The MDS indicated Resident #1 was at risk of developing pressure ulcers/injuries. The MDS did not indicate any unhealed pressure ulcers/injuries.Record review of the care plan last revised on 10/15/25 indicated Resident #1 was at risk for impairment to skin integrity related to fragile skin, incontinence, impaired mobility, diabetes, and nutritional and hydration risk. There was an intervention to identify and document potential causative factors and eliminate and resolve where possible.Record review of a Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] indicated a score of 21 which indicated Resident #1 was not at risk for pressure injury. The electronic medical record for Resident #1 did not indicate any further assessments from 06/04/25 - 02/28/26.Record review of a Skin Check assessment dated [DATE] indicated Resident #1 had no skin issues. The electronic medical record for Resident #1 did not indicate any further assessments from 01/27/26 - 02/28/26.Record review of an At Risk Skin Assessment Visit by wound care nurse practitioner dated 02/02/26 for Resident #1 indicated, .no new skin abnormalities were observed.no active wounds.Routine skin assessment was performed in a high - risk patient. Patient remains at increased risk due to age, History of Fall.Other Reduced Mobility. Continue skin surveillance at routine intervals. Record review of a Change of Condition Progress note dated 02/25/26 at 1:00 p.m. for Resident #1 indicated, .Resident has small wound on buttock. The note was signed by LVN A.Record review of a Progress Note dated 02/25/26 at 1:59 p.m. for Resident #1 indicated, .Resident has small wound to buttock upon checking aide noticed that stool was dark. Resident appeared to have black tarry stool.EMS (emergency medical services) was called and resident was sent to (hospital). The note was signed by LVN A.Record review of a hospital Wound Care Nurse Note dated 02/26/26 at 1:20 p.m. for Resident #1 indicated the resident had been admitted to the hospital on [DATE] for [NAME] (the passage of black, tarry, foul-smelling stools, indicating upper (continued on next page)

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

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