STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interviews and record review the facility failed to ensure residents were free from abuse for 1 of 8 residents (Resident #1) reviewed for resident abuse. The facility did not ensure Resident # 1 was free from abuse on 2/20/25 when he was slapped on the top of his hand. The noncompliance was identified as PNC. The noncompliance began on 2/20/25 and ended on 2/20/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of physical harm, mental anguish, or emotional distress. The findings included: Record Review of Resident #1's face sheet dated 11/20/24 indicated Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Dysphagia (Difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), Cognitive Communication Deficit (Cognitive communication is the mental skills used to process information and communicate with others), Mild Cognitive Impairment (a condition characterized by a subtle decline in cognitive abilities, such as memory, attention, and reasoning, that is not severe enough to interfere with daily functioning). Record Review of Resident #1's MDS assessment dated [DATE] indicated, Resident #1 usually understood others and usually made himself understood. The MDS assessment indicated Resident #1 had a BIMS score of 03, which indicated Resident #1 had severe cognitive impairment. Indicated that Resident #1 never rejected care. Record Review of Resident #1's care plan, dated on 3/03/25, indicated Resident #1 requires tube feeding, is non-compliant with feeding and will eat other resident's food. Resident #1 has impaired cognitive function and has impaired thought processes. Resident #1 has a behavior he will open up his percutaneous endoscopic gastrostomy tube and suck the contents from his stomach. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/25 at 3:31 p.m. CNA B said that on 2/20/25 that morning when she was passing breakfast trays, she could hear LVN A being loud in the room with Resident #1. She said she was curious of what was going on and that was when she heard LVN A hit the top of the hands of Resident #1. She said you could hear the skin-on-skin contact. She said she did not lightly tap the hands of Resident #1 but hit them hard like a slap. She said that Resident #1 was not crying and did not appear to be in any distress. She said she asked LVN A what was going on and she said she was trying to get Resident #1 to move his hands so she could feed him. She said that CNA C entered the room also to see what was going on. She said she told CNA C to go report what happened to their supervisor who then told the Administrator what happened. She said she never left Resident #1's side until after management got involved. She said she was trained on abuse and neglect, the timeframes and requirements for reporting abuse and neglect. She said that was how she knew to report and stay with the resident. She said she was then trained again in abuse and neglect after the incident. During an interview on 3/3/25 at 3:40 p.m., the Administrator said that she did not witness the incident, but it was reported that CNA B witnessed LVN A hit the top of the hands of Resident #1 and that CNA C heard the skin on skin contact as well. She said that LVN A did speak loudly but she has never verbally abused anyone. She said LVN A speaks loudly because she was hearing impaired. She said that after the incident LVN A was suspended, a report was made to the Texas Health and Human Services Commission, and Resident #1 was assessed for any physical injury. She said that there was no physical injury, so he was evaluated by a counseling agency to determine if he had any trauma. Resident #1 who has a BIMS of 3 did not recall the incident, said the incident did not happen, and was not in any distress due to the incident. She said that after the incident occurred an investigation was started, and staff were re-trained on abuse and neglect. During an interview on 3/3/25 at 3:54 p.m. Resident #1 was asked questions in an answer question format as he was unable to give full responses. Question: Resident #1 did you know LVN A? Answer: Yes. Question: Did LVN A hit you on the hand? Answer: No. Question: Resident #1 do you feel safe here? Answer: Yes. During an interview on 3/3/25 at 4:05 p.m., CNA C said that on 2/20/25 while breakfast trays were being passed out, she heard a commotion in Resident #1's room. She said before she entered the room, she heard two loud slapping sounds. She said it sounded like skin-on-skin contact. She said when she entered the room CNA B was already inside and she said, She just hit him. She said she saw LVN A sitting with Resident #1 who was being fed. She said LVN A was being loud with the resident saying, Don't do that. She said CNA B said she needed to go get a supervisor. She said she then left the room and told a supervisor. She said she had been trained in abuse and neglect and was trained again after the incident. She said that when abuse or neglect occurs she should report to a supervisor or the Administrator what happened, ensure the resident is safe, and not allow the alleged perpetrator to stay with the resident. During an interview on 3/4/25 at 8:50 a.m., LVN A said that on 2/20/25 she was feeding Resident #1. She said that Resident #1 has a history of interfering when he was being fed and pulling at his Gtube (a feeding tube). She said that on this day he was also pulling at his Gtube. She said she said to him in a loud voice, Stop and Don't do that. She said she did touch Resident #1's hands but it was to move them to his side. She said she did not tap or hit the hands of Resident #1. She said she was only trying to keep him from removing his Gtube. She said that CNA B and CNA C did not see what happened and they were both lying. She said they were both outside in the hallway and neither of them saw or heard her hit Resident #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 3/4/25 at 9:05 a.m. CNA B was asked to demonstrate the force used when she witnessed LVN A hit the top of Resident #1's hands. CNA B demonstrated what she witnessed, and the force used was very strong making aloud slapping noise on the table. She said that LVN A hit the top of Resident #1's hands very hard and it was not a light tap as if a child was being scolded. During multiple staff interviews on 3/4/25 staff were able to identify the elements of abuse and neglect, timeframes for reporting abuse and neglect, who to report to, and that the resident involved should be made safe. Staff were also able to say that the alleged perpetrator should not have access to the alleged victim. During an interview on 3/4/25 at 11:50 a.m., the Director of Nurses said that all newly hired staff and on occasion staff were trained in their abuse and neglect policy. She said staff were trained on when to report, who to report to, and how to protect residents that were suspected of being abused or neglected. She said she expects all her staff to follow facility policy regarding abuse and neglect. She said that a resident was placed at risk of harm if a staff abused them. During an interview on 3/4/25 at 11:55 a.m., the Administrator said that the facility has developed abuse and neglect policies. She said that either herself or the Director of Nurses was to conduct the training. She said that their abuse and neglect policy teach on when to report abuse, who to report abuse to, and how to protect the resident if abuse was suspected or occurred. She said she expects that her staff would intervene if they see or suspect that abuse or neglect occurs. Record review of the facility's provider investigation report dated 2/20/25 revealed that the facility conducted an investigation into the allegations that LVN A physically abused Resident #1 when CNA A observed LVN A hit Resident #1 on the top of his hands while LVN A was feeding the resident. The report showed that the time and date of the incident was 2/20/25 at 8:15 a.m. and that Resident #1 was physically assessed on 2/20/25 at 9:43 a.m. Further review showed that the incident was reported to the Texas Health and Human Services Commission on 2/20/25 at 10:01 a.m. Record review of a skin assessment for Resident #1 dated 2/20/25, indicated that there were no skin impairments. Skin assessment was completed after the incident. Record review of a trauma assessment for Resident #1 dated 2/20/25, indicated that there was no present trauma. Resident # 1 indicated no to the following questions: Has the event caused you to felt very scared, helpless, or horrified Has the event caused you to be constantly on guard, watchful, or easily startled Has the event caused you to feel numb, detached from others, actives, or your surroundings. Record review of facility in-service dated 2/20/25 titled, Abuse and Neglect conducted by the Director of Nurses. In-service training reviewed the facilities abuse and neglect prohibition policy. Policy identified elements of abuse and timeframes for reporting abuse. Record review of LVN A's personnel file on 03/4/25 indicated hire date of 1/15/19. The facility had performed background check and employee misconduct search. No concerns were identified. Record review of LVN A's Corrective Action Memo, dated 2/25/25, indicated she was terminated for misconduct regarding allegations of Abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The noncompliance began on 02/20/25 and ended on 02/20/25. The facility had corrected the noncompliance before the investigation began. The surveyor confirmed PNC had been implemented sufficiently to remove the deficiency by: Facility notification of abuse incident to responsible party, MD, Ombudsman and HHSC. Completion of in-services on abuse. Staff and management recognizing the steps to report abuse and neglect. Termination of confirmed perpetrator. Record Review of facility policy titled, Abuse Prevention and Prohibition dated 8/2020. Policy indicated, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.