STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675185	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Healthcare Center	120 Meadowview Dr Justin, TX 76247

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** 50444 Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #1) of 6 residents reviewed for abuse and neglect. The facility failed to notify Resident #1's attending physician and representative after Resident #2 reported CNA B raised her voice and used inappropriate language while caring for Resident #1 who was on Hospice. CNA B was in the room getting Resident #1 ready for bed. Resident #2 stated she heard CNA B say loudly shut the fuck up to Resident #1 on 03/13/2025. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. The findings included: Record review of Resident #1's face sheet, dated 04/17/2025, reflected the resident was a [AGE] year old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included senile degeneration of the brain (decline in memory, behavior, and cognitive ability), epilepsy (brain condition that causes recurring seizures), and unspecified psychosis (loss of touch with reality) not due to a substance or known physiological problem. Record review of Resident #1's MDS (tool used to assess health status) Assessment, dated 02/28/2025, reflected a BIMS (tool used to assess cognitive function) score of 00 indicating severe cognitive impairment. Section GG indicated Resident #1 was dependent on staff for most self-care needs. Section O reflected Resident #1 was on hospice care services. Record review of Resident #1's Comprehensive Care Plan, dated 02/20/2025, reflected the resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t disease process Interventions included All staff to converse with resident while providing care and Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/17/2025 at 10:27 AM, Resident #1 was sitting in the hall in her wheelchair across from the nurse's station. Resident #1 did not reply when the surveyor said hello. She smiled and looked ahead. A staff member took Resident #1 to her room and stated Resident #1 was hard of hearing and you had to talk loudly for her to hear you. Resident #1 was not able to answer any questions due to her cognitive status. Resident #1 moved her wheelchair toward the door and called help me. Staff assisted Resident #1 back into the hall where she was content to sit across from the nurses' station During an interview on 04/17/2025 at 10:32 AM, Resident #2 stated Resident #1 had been her roommate for quite a while. She stated Resident #1 did not like to stay in the room and preferred to sit in the hall. She stated Resident #1 did not communicate other than saying help me. She stated a few days prior, CNA B was in the room getting Resident #1 ready for bed. She stated she heard CNA B say loudly shut the fuck up. Resident #2 stated she reported it to the ADON. She stated she thought CNA B was talking to Resident #1. Resident #2 stated did not see anyone else in the room and did not think CNA B was talking on the phone. She stated after CNA B put Resident #2 to bed, she shut the door and left the room. Resident #2 stated she had never heard CNA B talk like that. She stated she had not observed any changes in Resident #1's behavior since the incident. She stated you have to talk loudly and make sure Resident #1 can see your lips when speaking to her. Resident #2 stated she had no concerns about her care. She stated the staff was respectful to her and she felt safe. Resident #2 said the incident didn't bother her because she had heard worse in her life. She stated staff members came several times to talk with her and make sure she was ok after the incident Record review on 04/17/2025 at 11:45 AM revealed no documentation of Resident #1's representative or physician being notified. During an interview on 04/17/2025 at 12:01 PM, the DON stated she was told Resident #1 was lying in bed and CNA B was changing her when Resident #2 heard CNA B yell those words. The DON stated she had been at the facility for about nine months and CNA B was working at the facility when she came. She stated there had been no complaints about CNA B from any other residents. She stated the ADON reported the incident to her after Resident #2 told the ADON what she heard. The DON stated she immediately reported it to the administrator. She stated CNA B was not working the day it was reported but was scheduled to work the weekend. She stated CNA B was immediately suspended pending an investigation. The DON stated the following Monday CNA B came to the facility and spoke with her. The DON stated CNA B said she was flustered but was not yelling at the resident and would never yell at a resident. She stated CNA B was terminated. She stated if CNA B was talking to a resident or in their presence, that type of behavior was not tolerated. She stated it could affect both residents emotionally. She stated they had observed no changes in Resident #1's behavior and there were no medication changes. The DON stated in-service training was provided on abuse and neglect and residents' rights. The DON reviewed the resident's medical record and the facility's investigative report and stated there was no record of any staff member reporting the incident to the resident's family or physician. During an interview on 4/17/2025 at 12:11 PM, Resident #1's family member stated the facility had not told her about the incident. She stated Resident #1 cannot hear and you had to yell when speaking to her. She stated she came to the facility daily to visit Resident #1 and the CNAs were all great. She stated staff called her with any changes. She stated the roommate tells her everything but had not mentioned the incident. (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 on 04/17/2025 at 1:15 PM, the Social Worker stated she had worked at the facility for about 6 months. She stated she was not aware of a facility report involving Resident #1. She stated Resident #1's family member came to the facility daily to bring a snack and visit. During an interview on 04/17/2025 at 2:33 PM, LVN A stated a nurse should call any report any changes of status to the resident's family and physician. She stated if a resident falls, you call and report to the physician and family. She stated she would ask the DON or Administrator for guidance because she had not experienced a resident reporting something like that. During an interview on 04/17/2025 at 2:43 PM, the ADON stated Resident #2 reported the incident to her on a Wednesday and Resident #2 told her it happened the prior Thursday. The ADON stated Resident #2 told her CNA B was in the room proving care for Resident #1 and Resident #2 heard CNA B say, shut the fuck up. The ADON stated she reported it immediately to the Administrator and DON. She stated CNA B was off work when Resident #2 reported the incident. The ADON stated she wrote a statement about what she was told. The ADON stated she did not write an incident report. She stated she was uncertain about the protocol for reporting to family and physician when an employee was involved in an incident. She stated the facility made sure CNA B had no further contact with any residents. She stated that behavior could make residents afraid to ask CNA B for help after hearing her yell. During an interview on 04/23/2025 at 1:45 PM, the Hospice Administrator stated a hospice nurse went to the facility after the physician's office received a message to call the surveyor. She stated the hospice nurse's note reflected upon arriving at the facility she was told about the self-reported incident. The Hospice Administrator stated the facility provided the hospice nurse with a copy of the report. The Hospice Administrator stated if the facility had not reported it, hospice would be required to. She stated the hospice nurse's report reflected she educated the facility on notifying hospice at the time an incident occurred. Attempts were made to interview CNA B on 04/17/2025. There was a recorded message the person was unavailable with no option to leave a voicemail. Review of facility policy Notifying The Physician of Change in Status, Revised March 11, 2013, reflected 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record .5. The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews and record review, the facility failed to review and revise the comprehensive person-centered care plan for each resident consistent with the residents rights' that included measurable objectives and time frames to meet the medical, physical, and psychosocial needs identified in the comprehensive assessment for 1 (Resident #1) of 6 residents reviewed for care plan reassessment and revision. The facility failed to review and revise Resident #1's comprehensive care plan after her roommate (Resident #2) reported CNA B raised her voice and used inappropriate language while caring for Resident #1 who was on Hospice. CNA B was in the room getting Resident #1 ready for bed. Resident #2 stated she heard CNA B say loudly shut the fuck up to Resident #1 on 03/13/2025. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. The findings included: Record review of Resident #1's face sheet, dated 04/17/2025, reflected the resident was a [AGE] year old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included senile degeneration of the brain (decline in memory, behavior, and cognitive ability), epilepsy (brain condition that causes recurring seizures), and unspecified psychosis (loss of touch with reality) not due to a substance or known physiological problem. Record review of Resident #1's MDS (tool used to assess health status) Assessment, dated 02/28/2025, reflected a BIMS (tool used to assess cognitive function) score of 00 indicating severe cognitive impairment. Section GG indicated Resident #1 was dependent on staff for most self-care needs. Section O reflected Resident #1 was on hospice care services. Record review of Resident #1's Comprehensive Care Plan, dated 02/20/2025, reflected the resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t disease process Interventions included All staff to converse with resident while providing care and Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities. During an observation and interview on 04/17/2025 at 10:27 AM, Resident #1 was sitting in the hall in her wheelchair across from the nurse's station. Resident #1 did not reply when surveyor said hello to the resident. She smiled and looked ahead. The staff member brought Resident #1 to her room so the surveyor could interview her and stated Resident #1 was hard of hearing and you had to talk loudly for her to hear you. Resident #1 was not able to answer questions due to her cognitive status. Resident #1 did not want to be in the room, moved her wheelchair toward the door, and called help me. Staff assisted Resident #1 back into the hall where she was content to sit across from the nurses' station. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 10:32 AM, Resident #2 stated Resident #1 had been her roommate for quite a while. She stated Resident #1 did not like to stay in the room and preferred to sit in the hall. She stated Resident #1 did not communicate other than saying help me. She stated a few days prior, CNA B was in the room getting Resident #1 ready for bed. She stated she heard CNA B say loudly shut the fuck up. Resident #2 stated she reported it to the ADON. She stated she believed CNA B was talking to Resident #2. Resident #1 stated she did not see anyone else in the room and did not think CNA B was talking on her phone. She stated after CNA B put Resident #2 to bed, she shut the door and left the room. Resident #1 stated she had never heard CNA B talk like that. She stated she had not observed any changes in Resident #2's behavior since the incident. She stated you have to talk loudly and make sure Resident #2 can see your lips when speaking to her. Resident #2 stated she had no concerns about her care. She stated the staff was respectful to her and she felt safe. Resident #2 said the incident didn't bother her because she had heard worse in her life. She stated staff members came several times to talk with her and make sure she was ok after the incident. Record review on 04/17/2025 at 11:45 AM revealed Resident #1's Comprehensive Care Plan was not updated, after CNA B raised her voice and used inappropriate language while providing care for Resident #1, to include interventions ensuring Resident #1's needs were met. During an interview on 04/17/2025 at 12:01, the DON stated she was told Resident #1 was lying in bed and CNA B was changing her when Resident #2 heard CNA B yell those words. The DON stated she had been at the facility for about nine months and CNA B was working at the facility when she started. She stated there had been no complaints about CNA B from any other residents. She stated the ADON reported the incident to her after Resident #2 told the ADON what she heard. The DON stated she immediately reported it to the administrator. She stated CNA B was not working the day it was reported but was scheduled to work the weekend. She stated CNA B was immediately suspended pending an investigation. The DON stated the following Monday CNA B came to the facility and spoke with her. The DON stated CNA B said she was flustered but was not yelling at the resident and would never yell at a resident. She stated CNA B was terminated. She stated if CNA B was talking to a resident or in their presence, that type of behavior was not tolerated. She stated it could affect both residents emotionally. She stated they had observed no changes in Resident #1's behavior and there were no medication changes. The DON stated in-service training was provided on abuse and neglect and residents' rights. The DON looked at the resident's chart and stated the resident's care plan was not updated after the report but she would immediately update it. During an interview on 04/17/2025 at 3:34 PM, the MDS Coordinator stated when concerns are presented at morning staff meetings, they discuss at that time who will put in a care plan. She stated a care plan could be added or updated by the MDS Coordinator, the DON, social worker, or another nurse. She stated the MDS Coordinators did not add acute care plans. She stated she had seen care plans for resident-to-resident interactions but was not sure about a staff member to resident incident. Review of facility policy, Comprehensive Care Planning reflected Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan. Undated.