STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675913	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Care Center	521 S Heatherwilde Blvd 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interviews and record review, the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of six residents reviewed for quality of care. The facility failed to ensure Resident #1 was assessed by a nurse before CNA A got him off the floor after an unwitnessed fall on 01/14/25. This failure could place residents at risk of not receiving necessary medical care, harm, injury, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia, repeated falls, and age-related physical debility. Review of Resident #1's quarterly MDS assessment, dated 01/08/25, reflected a BIMS could not be conducted due to him rarely/never being understood. Section J (Health Conditions) reflected he had two or more falls since the prior assessment. Review of Resident #1's quarterly care plan, dated 10/01/24, reflected he was at risk for falls related to poor safety awareness and decreased balance/strength with an intervention of anticipating and meeting the resident's needs. Review of Resident #1's admission (from the hospital) Fall-Risk Assessment, dated 01/15/25, reflected he was a high fall risk. Review of Resident #1's progress note, dated 01/14/25 at 8:54 AM and documented by LVN B, reflected the following: [CNA A] wheeled [Resident #1] to the NSG station and [sic] reported he was found OOB on the floor; she reported, she recovered him from the floor and put him in the W/C . (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/25 at 2:22 PM, CNA A stated she knew better than to pick a resident up off the floor before getting a nurse to assess them. She stated it was important for a nurse to assess the resident if found on the floor because they could be injured. She stated the day she found Resident #1 on the ground (sitting on his bottom), she panicked because he was impulsive, and she was worried he would try to get up on his own and fall again. She stated it was a mistake and it should not have happened. She stated she immediately took him to LVN B, and he assessed Resident #1. She stated she was in-serviced on resident falls after the incident. During a telephone interview on 01/28/25 at 2:07 PM, the NP stated she was notified of Resident #1's fall. She stated if a fall was not witnessed, she would expect the aides to get a nurse to assess the resident before getting them off the ground. She stated a negative outcome could be if they had a head injury, it could make it worse. During an interview on 01/28/25 at 2:10 PM, the DON stated she was aware of the incident regarding CNA A getting Resident #1 off the ground before a nurse assessed him. She stated Resident #1 was assessed by LVN B and was not injured. She stated CNA A received a disciplinary action, 1:1 training, and all the staff were in-serviced. She stated CNA A admitted what she did was wrong, and she made a mistake by impulsively getting him off the floor. She stated if a resident was found on the ground, a nurse needed to take their vitals and assess for possible injuries. She stated if not assessed first, a resident could be further injured. An interview was attempted by telephone with LVN B on 01/28/25 at 12:49 PM. A call was not returned prior to exiting. Review of in-services entitled Fall Prevention, dated 01/14/25 and 01/16/25 and conducted by the DON, reflected all staff were in-serviced on fall prevention and their fall policy and procedure. Review of the facility's Preventative Strategies to Reduce Fall Risk Policy, revised October 5, 2016, reflected the following: Policy: The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility.