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	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Care Center	521 S Heatherwilde Blvd Pflugerville, TX 78660

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that medical records were accurately documented for four(Resident #1, Resident #2, Resident #3, and Resident #4) of six residents reviewed for accurate medical records. The facility failed to have documentation that they provided care to Resident #1 from 10pm to 6am from [DATE] - [DATE]. Resident #1 was on hospice and found deceased around 6am and there was no information of what care was to be provided during rounds or that Resident #1 was having a change of condition that required intervention. The facility failed to have documentation that they provided care to Residents #2, #3, and #4 from 10p to 6a from [DATE] - [DATE]. These failures could place residents at risk of not receiving timely care and services, accidents, harm, and death. Findings include: Resident #1 Review of Resident #1's admission Record, dated [DATE], reflected she was a [AGE] year old female who was admitted to the facility on [DATE], had a DNR, was receiving hospice services, and expired at the facility on [DATE]. Resident #1 had medical diagnoses that included spastic quadriplegic cerebral palsy (high muscle tone leading to stiffness and difficulty with movement that affects all four limbs, the trunk, and the face), intellectual disabilities, abnormalities of gait and mobility, other lack of coordination, and need for assistance with personal care. Review of Resident #1's Quarterly MDS, dated [DATE], reflected no BIMS documented and she was dependent on staff for all ADL care. Resident #1 was also always incontinent with urine and bowel movements. Review of Resident #1's Death in Facility MDS, dated [DATE], reflected she was discharged after expiring at the facility on [DATE]. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Care Plan, initiated [DATE], reflected she required two CNAs to assist her with bed mobility and mechanical lift transfers, one CNA to assist her with eating/drinking, dressing, and was dependent on CNAs for incontinent care and personal hygiene. CNAs were required to turn/reposition and provide incontinent care at least every two hours. Review of Resident #1's Progress Notes for [DATE] reflected there were no notes on [DATE] from 10:00 p. m. through 6:00 a.m. on [DATE]. Review of Resident #1's MAR/TAR for [DATE] reflected there were three entries from LVN B on [DATE] during the night shift, but the entries did not indicate when LVN B administered medications and treatments on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Review of Resident #1's MAR Audit Report for [DATE] reflected there were no results as to when LVN B documented the three entries on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Review of Resident #1's Vital Summary reflected LVN B took the following vitals on [DATE] at 1:27 a.m.: -Temperature 97.5 degrees Fahrenheit -Respirations 18 breaths per minute -Pulse 72 beats per minute -Oxygen Saturation 95% -Blood Pressure 124/74 millimeters of mercury Review of Resident #1's POC for [DATE] reflected there were no entries for ADL assistance, bed mobility, bowel incontinence, dressing, personal hygiene, hands on assistance with eating/drinking, mechanical lift transfers, thickened liquids, skin observation, snacks and fluids, toilet use, transferring, turning/repositioning, walk in corridor, and walk in room assistance on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Review of Resident #1's Postmortem Assessment, signed by LVN A on [DATE] at 6:22 a.m., reflected Resident #1 was found in her bed in her room unresponsive, without respirations and pulse, fixed and dilated pupils, and body temperature indicated hypothermia and skin was cold relative to her baseline skin temperature. Resident #1 was pronounced dead by the Hospice Agency RN on [DATE] at 7:18 a.m. Review of Resident #1's Discharge Summary, signed by LVN A on [DATE] at 9:39 a.m., reflected on [DATE] at 6:22 a.m., she was observed unresponsive, without carotid pulse and breath, and with fixed/dilated pupils. Resident #2 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's admission Record, dated [DATE], reflected she was an [AGE] year old female who was admitted to the facility on [DATE], had a DNR, and was receiving hospice services. Resident #2 had medical diagnoses that included senile degeneration of the brain (a group of neurological disorders that cause a progressive decline in cognitive function, including memory, reasoning, and problem-solving), generalized muscle weakness, other lack of coordination, adjustment insomnia (a type of sleep disorder that occurs when a specific stressful event or change in a person's life disrupts their normal sleep patterns), Alzheimer's disease (a progressive, neurodegenerative disorder that primarily affects the brain and causes a decline in cognitive function, particularly memory and thinking), other chronic pain, and repeated falls. Review of Resident #2's Quarterly MDS, dated [DATE], reflected no BIMS documented and she was dependent on staff for all ADL care. Resident #2 was also always incontinent with urine and bowel movements. Review of Resident #2's Care Plan, revised on [DATE], reflected she required two CNAs to assist her with bed mobility, toileting, dressing and mechanical lift transfers and one CNA to assist her with eating/drinking and personal hygiene. CNAs were required to provide incontinent care and turn/reposition her at least every two hours. Review of Resident #2's POC for [DATE] reflected there were no entries for ADL assistance, bed mobility, bowel incontinence, dressing, personal hygiene, hands on assistance with eating/drinking, mechanical lift transfers, skin observation, snacks and fluids, toilet use, transferring, turning/repositioning, walk in corridor, and walk in room assistance on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Resident #3 Review of Resident #3's admission Record, dated [DATE], reflected she was a [AGE] year old female who was admitted to the facility on [DATE], had a DNR, and was receiving hospice services. Resident #3 had medical diagnoses that included vascular dementia (a type of dementia caused by damage to the blood vessels in the brain, leading to reduced blood flow and oxygen supply), overactive bladder, other lack of coordination, abnormalities of gait and mobility, dementia (a general term for the decline in memory, thinking, and reasoning skills, affecting daily life), insomnia, and need for assistance with personal care. Review of Resident #3's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 10, which indicated she had moderate cognitive impairment. Resident #3 also required supervision with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with showering, dressing, personal hygiene, bed mobility, and dependent on staff for toileting, and transfers. Resident #3 was also always incontinent with urine and bowel movements. Review of Resident #3's Care Plan, revised [DATE], reflected she required two CNAs to assist her with bed mobility, toileting, dressing and mechanical lift transfers, one CNA to supervise her with eating/drinking, and one CNA to assist her with personal hygiene. CNAs were required to provide incontinent care and turn/reposition her at least every two hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's POC for [DATE] reflected there were no entries for ADL assistance, bed mobility, bowel incontinence, dressing, high risk for falls monitoring, personal hygiene, hands on assistance with eating/drinking, mechanical lift transfers, skin observation, snacks and fluids, toilet use, transferring, turning/repositioning, walk in corridor, walk in room assistance and behavior monitoring on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Resident #4 Review of Resident #4's admission Record, dated [DATE], reflected she was an [AGE] year old female who was admitted to the facility on [DATE], had a DNR, and was receiving hospice services. Resident #4 had medical diagnoses that included Alzheimer's disease, convulsions (involuntary, rhythmic muscle contractions and relaxations that cause uncontrolled shaking and jerking of the body, often accompanied by a temporary loss of consciousness), generalized muscle weakness, abnormalities of gait and mobility, other lack of coordination, dementia and need for assistance with personal care. Review of Resident #4's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 3, which indicated she had severe cognitive impairment and she was dependent on staff for all ADL care. Resident #4 was also always incontinent with urine and bowel movements. Review of Resident #4's Care Plan, revised [DATE], reflected she required two CNAs to assist her with bed mobility, toileting, and mechanical lift transfers and one CNA to assist her with dressing, eating, and personal hygiene. CNAs were required to provide incontinent care and turn/reposition her throughout the day and as needed. Review of Resident #4's POC for [DATE] reflected there were no entries for ADL assistance, bed mobility, bowel incontinence, dressing, personal hygiene, mechanical lift transfers, skin observation, snacks and fluids, toilet use, transferring, turning/repositioning, walk in corridor, and walk in room assistance on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. Review of the facility's Staff Schedule, dated [DATE], reflected LVN B and CNA C were assigned to work on Residents #1, #2, #3, and #4's hallway on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE]. LVN A and CNA G were also assigned to work on Residents #1, #2, #3, and #4's hallway on [DATE] from 6:00 a.m. through 2:00 p.m. Attempts to call CNA C were made on [DATE] at 12:48 p.m. and [DATE] at 9:44 a.m. CNA C did not return the calls before exit. Attempts to call LVN B were made on [DATE] at 12:50 p.m. and [DATE] at 9:49 a.m. LVN B did not return the calls before exit. During a group interview with CNA D and CNA E on [DATE] at 1:08 p.m., they stated CNAs and nurses were responsible for checking on and providing treatment and care to residents at least every two hours. They stated CNAs documented care in residents' POC during their shift. They stated residents needed to be checked on and provided treatment and care so they did not develop worsening conditions. They stated the DON reminded CNAs daily to check on and provide care to residents at least every two hours, as needed, or upon request. They stated the nurses, ADON and DON were responsible for overseeing and ensuring CNAs checked on and provided care to residents daily by asking the CNAs if they were performing care on residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A on [DATE] at 1:18 p.m., he stated the CNAs and nurses were responsible for checking on and providing treatment and care to residents at least every two hours. He stated CNAs documented care in residents' POC after completing the task and said, If the CNAs did not do it right away, then they could forget to document later. LVN A stated he did not know where the nurses documented treatment and care after completing the task. LVN A stated residents could be at risk of developing injuries and other worsening conditions if they were not being checked on and provided treatment and care. He stated the ADON reminded the CNAs and nurses every couple of days about checking on and providing treatment and care to residents. LVN A stated he did not know who was responsible for overseeing and ensuring CNAs and nurses checked on and provided treatment and care to residents, but he believed residents' POCs were reviewed to ensure CNAs completed the tasks. LVN A stated he believed he found Resident #1 unresponsive during his first set of rounds on [DATE]. LVN A stated he was unsure if Resident #1 had been expired for some time on [DATE] when he conducted her postmortem assessment on [DATE]. LVN A stated he described Resident #1's body temperature as hypothermia and skin was cold relative to her baseline skin temperature because that was one of the options the postmortem assessment provided while he completed the assessment. LVN A stated he recalled speaking with the previous shift (LVN B), who worked on [DATE] from 10:00 p.m. through 6:00 a.m. on [DATE] and he believed there were no reported concerns from the previous shift (LVN B). During an interview with RN F on [DATE] at 1:39 p.m., she stated CNAs and nurses were responsible for checking on and providing treatment and care to residents at least every two hours, as needed, and as requested. She stated CNAs documented care in residents' POC after completing the task. She also stated nurses documented treatment and care in residents' TAR after completing the task. She stated residents could be at risk of worsening conditions if they were not being checked on and provided treatment and care. She stated the ADON and DON in-serviced CNAs and nurses on checking on and providing treatment and care frequently. She also stated the ADON and DON were responsible for overseeing and ensuring CNAs and nurses checked on and provided treatment and care to residents. During an interview with the ADON on [DATE] at 2:23 p.m., she stated CNAs and nurses were responsible for checking on and providing treatment and care to residents at least every two hours, as needed, and upon request. She stated CNAs documented care in residents' POCs. She stated nurses documented care in residents' progress notes. She stated she and the DON reminded the CNAs and nurses daily about checking on and providing treatment and care. She stated she and the DON were also responsible for overseeing and ensuring CNAs and nurses were checking on and providing treatment and care by reviewing residents' POCs daily and reeducating if needed and said, Whatever was in the care plan was in POC and must be completed. During an interview with the ADM on [DATE] at 9:30 a.m., he stated the facility did not have policy and procedure on rounding or checking on residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MD on [DATE] at 10:37 a.m., he stated that he was unsure what the facility's expectations were on checking on residents and what frequency was acceptable. He stated that he would think residents should be checked on at least once a shift and said, Anything could happen in that time. Residents should be peeked on. If a resident could not express their needs or access their call button, that could be a problem. Should get in touch with those residents. Residents who have specific needs, such as being changed, definitely need to be checked on at least once a shift. Any changes in mental status that would be important as well. He also stated it was unacceptable to not check on a resident for a whole shift. He also said, If a resident were cold to touch when found deceased , which would indicate that resident was not breathing, had no pulse, and then someone would pronounce their death. If someone was cold to touch, they were probably dead for at least 4 hours, maybe 6 hours or so. I would guess probably 4-6 hours or so, maybe closer to 6 hours because there is lots of mass to corroborate before becoming cold. During an interview with the NP on [DATE] at 10:45 a.m., he stated that if a resident had a change in condition, he expected residents to be checked on more frequently. He also stated that he expected residents on hospice services to be checked on more frequently. He clarified that more frequently meant at least every two hours and explained the nurses and CNAs would alternate who checked on the residents every hour. He stated it was not acceptable to not check on residents for a whole shift and said, Still need to check on hospice or long term residents at least every two hours. Residents were different. If focus were pain management, resident could have uncontrollable pain and need to be checked on every shift. If resident were hospice resident, you never know when resident would have a change in condition. Residents needed to be checked on more often, that is why they were on hospice. He also said, If a resident is cold to touch when found deceased , it would indicate that resident was deceased for maybe 6 or 5 hours, but it depends on resident status and condition before the death. During a confidential interview with the CE on [DATE] at 11:35 a.m., they stated CNAs were expected to check on residents every hour and as many times as needed. They also stated CNAs were expected to document care in residents' POCs during their shifts. They stated another female CNA (CNA G) was already working on Resident #1's hall on [DATE] at 6:00 a.m. because CNAs worked in pairs of two on each hallway. They observed Resident #1 lying in her bed, her eyes were not open or halfway open, stiff when they tried to lift her arm, cold when they touched her, pale, head was turned in one direction, and they suspected Resident #1 was dead on [DATE] at 6:00 a.m. They stated they notified LVN A, asked when Resident #1 passed away. LVN A rushed over to the room, and notified the night shift nurse (LVN B). They stated no one knew that Resident #1 passed away and LVN A and LVN B tried to argue that Resident #1 had just passed away during the 6:00 a.m. through 2:00 p.m. shift on [DATE]. An attempt to call CNA G was made on [DATE] at 11:52 a.m. CNA G did not return the call before exit. Review of the facility's Care Plan policy and procedure, undated, reflected, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs . The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. Review of the facility's Documentation policy, dated 2003, reflected, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care. Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. Procedure .6. Document completed assessments in a timely manner and per policy. 7. Complete documentation in the electronic health record in a timely manner. Each entry will be dated and timed. Each entry will be signed with proper signature and title. 8. Documentation during and following an acute episode, following an event, and during physiologic, mental, or emotional changes or instability . 10. Document or check information on flow sheets each shift or as appropriate for the care or treatment being monitored.