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	01/06/2026

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 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** Based on interviews and record reviews, the facility failed to ensure residents were free from verbal abuse for 1 of 4 residents (Resident #1) reviewed for abuse. The facility failed to prevent [CNA B], from verbally abusing Resident #1 on 11/23/2025 at 3:15 PM. This failure could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. Findings included:Record review of Resident #1's admission record dated 01/06/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. His relevant diagnoses included: SCHIZOPHRENIA is characterized by(delusions, hallucinations and psychosis.), MAJOR DEPRESSIVE DISORDER (mood disorder that causes a persistent feeling of sadness), GENERALIZED ANXIETY DISORDER (a mental health condition that causes fear, worry and feeling of being overwhelmed).Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 06, indicating Resident #1's cognition was severely impaired. Section E- Behavioral Symptom reflected Resident #1 did not exhibit any behaviors.Record review of Resident #1's quarterly care plan assessment dated [DATE] reflected Resident #1 had the potential to demonstrate verbally abusive behaviors. Goal: The resident will demonstrate effective coping skills through the review date. Interventions include notifying the charge nurse of any abusive behaviors. During a phone interview of Family #1, dated 01/06/2026 at 2 p.m. it was revealed that Resident # 1 was upset because [CNA B] did not change the channel when he asked her to. Record review of [CNA A]s written statement she provided on 11/23/2025, reflected on Sunday 11/23/2025 I and [CNA C] were in [Resident #1]'s room to change him, and [CNA B] helped us change the resident. When we were done, [CNA B] started cursing at the resident. She said '[‘fuck me, no fuck yourself, you stupid ass. I have rights just like you] . She was very upset. I let the Charge Nurse know what was going on. Record Review of [CNA C]s written statement on 11/23/2025, reflected, on Sunday 11/23/2025, [CNA B] had [Resident # 1's bed control and she was raising the head of the bed. Resident # 1 asked [CNA B] for the control because he wanted to do it himself. I saw Resident # 1 with the remote in his hand and he was yelling at [CNA B], Fuck You!. Resident # 1 was very mad, and [CNA B] yelled back at him telling him We are here cleaning your ass!, Don't tell us Fuck you!, Resident # 1 and [CNA B] were both yelling at each other.Record Review of LVN A's written statement on 11/23/2025, reflected on Sunday 11/23/2025 at 3:15 PM, he stated, I was sitting at the nurse's station and a staff [CNA A]) reported to me that another staff [CNA B] had an altercation with Resident # 1. I spoke to [Resident # 1] who told me what happened. [CNA B] requested that she be able to apologize to Resident # 1, but I instructed her not to go into the resident room. During an interview on 01/06/2026 at 11:05 a.m., [CNA A]stated, I heard[CNA B] say to [Resident # 1] fuck you and she said, I've got rights just like you, you don't talk to me like that. [CNA A] stated she had been trained in ANE. [CNA A] stated, If a staff member uses foul language towards a resident, which could make them feel bad and possibly hurt their feelings. During an interview on 1/06/2026 at 11:39 a.m., with LVN A was approached by[CNA (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	A]to report an altercation between [CNA B] and Resident # 1. He stated [CNA A], [CNA B], and [CNA C] had just finished changing Resident # 1 when the altercation occurred. He stated, [CNA B] was remorseful for using foul language, but I said, you cannot go into the room and I reported the incident to the ADM. LVN A stated, [CNA B]'s employment has been terminated.During a phone interview on 1/06/2026 at 12:30 p.m., revealed [CNA B]stated, I was assisting 2 other [CNA A] s. I was using the remote control to the bed when Resident # 1 told me that he wanted to do it. So, I reached across the bed and the remote dropped on the resident. She stated, Resident # 1 said to her, [you are an ugly fucking face]. She stated I told him He was not to speak to me that way and then I repeated his words back to him. She stated, at that time, the other CNAs only heard me repeating those words to him. She stated, I was asked to leave the facility, and I was fired. During an interview on 01/06/2026 at 3:30 p.m., it was revealed that ADM had been informed of an altercation between Resident # 1 and [CNA B]immediately after the incident. [CNA B] was immediately removed from the facility by LVN A. An investigation was completed, and it was found that [CNA B]had been verbally abusive to Resident # 1. ADM was called by LVN A immediately after the incident. ADM stated, we followed procedure by removing the employee from the facility and assessing Resident # 1. Resident # 1's skin assessment was clear, and no injuries were noted. At time of resident assessment, it was reported that 'Resident did not exhibit any signs of distress'. Employee [CNA B]) was terminated, and a report was sent to the nursing board. He stated, it was their expectation that all residents should be always treated with dignity and the CNA should not have replied to Resident # 1 in such a derogatory manner. He stated a review of the employee's file confirmed that [CNA B] had been trained on ANE and Resident Rights during orientation. Record review of the facility's Abuse/ Neglect Policy dated 3/29/2018 reflected: Policy The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.Definitions3. Verbal Abuse, and use of oral or written or gestured language that willfully includes disparaging and derogatory terms to the resident.Training. The facility will train through orientation and on-going in- services on issues related to abuse/ neglect prohibition practices regularly. Prevention:The facility will provide the residents and staff with an environment free from abuse and neglect.