STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676181	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Atascosa	1855 W Goodwin Pleasanton, TX 78064

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation and mistreatment were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 4 residents (Resident #1) reviewed for reporting of allegation of abuse, in that: The facility failed to report to the State Survey Agency (Health and Human Services Commission) an allegation of sexual abuse made by Resident #1. This failure could place residents at risk for harm to include neglect and a diminished quality of life. The findings included: Record review of Resident #1's admission record, dated 10/15/25, reflected a [AGE] year-old female, admitted [DATE] with diagnoses to include bipolar disorder (mental health condition that causes extreme mood swings) and schizoaffective disorder (mental health condition that can include psychotic symptoms such as hallucinations or delusions). Record review of Resident #1's care plan, undated, reflected focus Psycho-social/Behavioral Risk, initiated 08/27/25, with intervention RISK-BEHAVIORS MONITORING-Calm and re-assure resident/patient is safe, initiated 08/27/25. Record review of Letters of Guardianship, certified July 22, 2005, reflected Resident #1's family member was appointed guardian of Resident #1, an incapacitated person. Record review of TULIP (online system to streamline Long Term Care applications like facility reports of incidents) from July 2025 to September 2025, accessed 10/15/25, reflected no self-reports reflecting Resident #1 having sexual abuse allegations. Record review of Nursing Progress Note, dated 07/23/25 at 12:05 AM and authored by LVN A, reflected resident woke up from her sleep telling nurse that she thinks something is wrong. She thinks her rapist is back and going to get her pregnant and she will die. Vital signs taken. Nurse asked resident if she thinks she was just having a bad dream, she got upset saying I don't believe her. Record review of Nursing Progress Note, dated 07/25/25 at 11:58 PM and authored by LVN A, reflected resident turned on call light and told nurse that her rapist [unknown male] was back but not in person, now he is raping her by computer using new technology. Record review of Nursing Progress Note, dated 07/30/25 at 03:15 AM and authored by LVN E, reflected . Per resident, 'I need to go to the hospital. I'm having a baby. It's [unknown male]'s baby. Nobody here will help me.'. Record review of Nursing Progress Note, dated 08/13/25 at 02:35 AM and authored by LVN D, reflected, . Resident began to speak of her rapist, who she states is named [unknown male], and believes he has changed form into facility aide. Record review of Nursing Progress Note, dated 08/19/25 at 11:44 PM and authored by LVN A, reflected, . Resident began to speak of her rapist, who she states is named [unknown male], and believes he has changed form into facility aide and her roommate. Record review of Nursing Progress Note, dated 09/20/25 at 09:39 PM and authored by LVN E, reflected, . Resident talking about [unknown male], raping [sic] me over and over again. My [family member] said to take a sleeping pill. I don't want to be raped again. He has rapped me three times.'. Interview on 10/15/25 at 09:21 PM, LVN A revealed Resident #1 had schizophrenia and hallucinations. She revealed Resident #1 had statements on and off and would refer to her rapist [unknown male]. She revealed Resident #1 would say people were transforming into [unknown male]. She revealed there was no one with this name that came into the facility. She revealed she reported this allegation to the DON and the DON told her to document everything in order to record Resident #1's delusions as Resident #1 had a history of delusion. LVN A further revealed if there was an allegation of abuse or neglect, she would report to ADM immediately. She revealed she should have called the Administrator to report this allegation. Interview on 10/16/25 at 10:01 AM, CNA B revealed Resident #1 had schizophrenia and would always mention she was raped. She revealed Resident #1 would say all kinds of statements and she would make sure to report these allegations to her nurse who would report to DON. She revealed there were no residents or staff members with this name. Interview on 10/16/25 at 10:13 AM, CNA C revealed Resident #1 hallucinated and had schizophrenia. She revealed she would say she was being raped in the facility. CNA C revealed she would report this allegation to her nurse. She revealed the DON knew about these allegations and would speak with Resident #1. Interview on 10/16/25 at 11:59 AM, LVN D revealed Resident #1 would have delusions at times but not every day. She revealed Resident #1 would say she had a rapist in the past and her roommate would change gender and become her rapist. She reported this to the DON about behaviors and delusions. Interview on 10/16/25 at 12:08 PM, LVN E revealed Resident #1 did make allegations of abuse, but Resident #1 had this issue prior. She revealed she reported this to her DON and the ADM immediately. Interview on 10/16/25 at 12:42PM, the DON and current ADM revealed they were aware of these allegations, but Resident #1 had these delusions