STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676245	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Nursing and Rehabilitation Center	104 Rex Kerwin Court 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 interview and record review the facility failed to ensure each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of 12 residents (Resident #1) reviewed for abuse and neglect. 1. The facility failed to prevent CMA A from mistreating Resident #1. CMA A threw a blanket on Resident #1's head and left the room without removing it from Resident #1's face who struggled to remove it herself. 2. The facility failed to ensure CMA A did not forcefully move Resident #1's jaw to administer medications while Resident #1 was not fully awake. These failures could place residents at risk for staff mistreatment. Findings include: Record review of Resident #1's care plan, dated 05/14/2026, reflected the problem: [Resident #1] is dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits with indicated interventions: all staff to converse with Resident #1 while providing care, and reflected the problem: The [Resident #1] has impaired cognitive function related to dementia with indicated interventions: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Provide the resident with necessary cues, reorient and supervise as needed. Record review of Resident #1's significant change in status MDS, dated [DATE], reflected a BIMS score of 2, which indicated severe cognitive impairment. Record Review of Resident #1 admission record, dated 07/02/2026, reflected an 86-years-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included atherosclerotic heart disease without angina pectoris (plaque buildup in heart arteries that reduces blood flow but doesn't cause chest pain), vascular dementia (damaged or blocked blood vessels restrict oxygen and nutrients to the brain which cases a decline in thinking skills), depression (a serious mood disorder that causes persistent sadness, loss of interest, and physical fatigue), anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable worry and fear), and need for assistance with personal care. Record review of camera recording, dated 06/15/2026 at 7:08:45 a.m., revealed CMA A applied force to Resident #1's chin while pulling it down and administering medications to Resident #1. Record review of camera recording, dated 06/15/2026 at 7:09:17 a.m., revealed CMA A threw a blanket on Resident #1's head after she attempted to administer medications, walked away from Resident #1, and left Resident #1's room without checking on Resident #1 and adjusting the blanket which Resident #1 was able to remove from her head, but struggled to cover her legs. Record review of complaint's letter, dated 06/25/2026 and revised on 06/28/2026, reflected: [CMA A] that gave [Resident #1] her morning medicine on 6/15/2026, entered, raised her head portion of the bed, spoke to her about waking up. (note [Resident #1] was in a deep sleep at the time) [CMA A] began by pushing into her left axilla area (armpit), then tapping on her head with her fingers. Which caused Resident #1 to turn her head to the right with a facial look that implied discomfort and confusion. She shoved the cup of I assume medication to her lips. But by just being woken up from a deep sleep Resident #1 did not respond quickly enough. These first steps were a total of 46 seconds. Then because [Resident #1] did not respond as quickly as [CMA A] wanted; the [CMA A] forcefully used a technique that is used when trying to get a patient to swallow pills that are in their mouth, NOT a (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	technique that is used to get someone to open their mouth. A technique that is softly used not in the abusive way she applied to [Resident #1]. After the force was applied, which could have caused severe injury to [Resident #1's] jaw, she shoves the cup back to her mouth to have her finish whatever was in the cup. Then she throws the blanket over [Resident #1's] head in a way that appears to be in an act to humiliation and out of agitation. Then the [CMA A] has a smirk on her face as she passed the camera and left the room. The [CMA A] left the bottom of the blanket up over [Resident #1's] head leaving her uncovered from the waist down and the bed inclined. During an interview on 07/02/2026 at 1:31 p.m., Resident #1's family member stated Resident #1 was at the facility just for a little longer than a month. She stated after reviewing the video recording, dated 06/15/2026, she saw Resident #1 was upset. She stated Resident #1 could not communicate and just could mumble. She stated she knew Resident #1 very well and it seemed to her she was depressed while she was at the facility, but she could not provide any examples of depressed behavior. She stated that Resident #1 seamed lethargic (a state of physical or mental sluggishness [no energy]) and she is more alert at other facility. Resident #1's RP stated she could really tell the difference between how Resident #1 was in this facility and the place she was now. She stated Resident #1's family visited her in the facility every day and did not notice any difference between behavior before and after the incident. She stated that Resident #1 did not display any fear towards any staff members. She stated she did not review a video recording every day and did not see the recording with a blanket incident, dated 06/15/2026, until 06/23/2026 night. She stated she contacted the DON on 06/24/2026 and the DON called her back, and they scheduled a meeting on 06/25/2026 where she presented the video recordings to the DON and ADM. She stated the facility initiated the investigation, and the DON told her they would put a one-on-one sitter to protect Resident #1 in the last few days she stayed at the facility. The observation of Resident #1was not completed due to Resident #1 was discharged from the facility on 06/26/2026. The interview with Resident #1 was not completed due to Resident #1 was not interviewable per Resident #1's MDS record review (BIMS score of 2, which indicated severe cognitive impairment) and interview with Resident #1's family member. During an interview on 07/02/2026 at 2:47 p.m., RN D stated she worked at the facility for 4 years and had ANE training last week. She was aware of reporting any signs of ANE to the ADM immediately. RN D stated she worked with Resident #1 in the memory unit on a regular basis. She stated she worked with Resident #1 on 06/15/2026 at 6 a.m. -6 p.m. She stated when she worked with Resident #1, she was always up in the dining room participating in activities. She stated nobody reported to her ANE and she did not see any signs of ANE with Resident #1 or other residents at the facility. During an interview on 07/02/2026 at 2:21 p.m., LVN E stated she had ANE in-services and learned to report immediately any types of abuse (verbal, physical, psychological, and financial). She stated she never observed or was notified that CMA A did not administer medications or abused residents in the memory unit or other floors in the facility. She assisted Resident #1 on occasions even though she was assigned to this resident as she was assigned to the other side of 100 hallway on the memory unit, but she observed her in the dining room without any signs of distress apparent to her. During an interview on 07/02/2026 at 3:21 p.m., LVN G stated she worked at the facility for a year and completed ANE training last week. She stated she learned about different types of abuse (verbal, physical, verbal, and mental) and the need for reporting any signs of ANE immediately to the ADM. She stated nobody reported to her ANE regarding Resident #1 or any other residents at the facility. LVN G stated she did not notice any apparent signs of distress in Resident #1 at the time of the incident or after it. She stated if she noticed staff threw a blanket on a resident's head or forcing medication to residents, she could consider it to be resident abuse and report it to the ADM immediately. During an interview on 07/02/2026 at 3:33 p.m., CMA B stated she worked with Resident #1 on the regular basis and did not see any difference in her behavior through her entire stay at the facility. She stated that she did not see any fear in her behavior or any other signs of ANE in Resident #1 or other residents at the facility. She stated she had regular training on ANE 2-3 days ago. She (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she learned if you see any ANE signs, report to ADM immediately, how to take care of residents with cognitive issues, how to administer medication when they were not awake, not forcing medications as residents had the right to refuse. If a blanket was thrown on a resident's face, it was an example of resident's abuse. If a resident was not able to take meds per their policy and training, they should wait, tell the nurse, and administer medication later or document that it was not administered. CMA B stated it was not acceptable to pull a resident's chin and force medication into the resident's mouth. During an interview on 07/02/2026 at 3:58 p.m., the DON stated she worked at the facility for 5 years, completed ANE training last week, and conducted ANE training along with the ADM to staff every two weeks on the pay day. She stated she learned and educated staff on different types of ANE: physical, verbal, financial, mental and reporting if noticed signs of ANE immediately to the ADM. She stated she learned about the ANE allegations for Resident #1 when her RPs came to the facility. She stated one of Resident #1's RPs presented the video recordings depicting Resident #1's abuse by CMA A. She stated CMA A was suspended pending investigation of ANE allegation immediately on 06/25/2026 and they terminated her after the investigation was concluded, a few days later. She stated when she reviewed the video footage depicting CMA A's forceful medication administration technique and throwing a blanket on Resident #1's head, it made her very upset. She stated this type of interaction with CMA A could negatively affect Resident #1's physical and mental state. She stated that Resident #1 was assessed when they found out of incident with CMA A and no physical or psychosocial distress was identified. She stated that observation of Resident #1 did not show any signs of distress as she did not demonstrate any fear or unusual behaviors. Record Review of MD report of Resident #1's History and Physical, dated 06/18/2026, which was two days after the incident, reflected: Dementia: no changes. No recent behavioral issues per staff. Continue current regiment. Continue hospice care. Depression: no changes. Continue current regiment. During an interview on 07/02/2026 at 4:10 p.m., the ADM stated that he worked at the facility for seven years and completed ANE training a few days ago. He stated that they provide ANE in-services to all staff every two months or after complaints or incident investigation. He stated that he educated staff on different types of ANE and the requirement of reporting to him any signs of ANE immediately. His phone as the ANE coordinator was posted in the building for all staff to call him any time. He stated that he received a complaint with allegation of abuse for Resident #1 on 06/25/2026. He stated that after the meeting with Resident #1's RPs and reviewing provided evidence including video footage from a camera located in Resident #1's room, he initiated the investigation immediately. He stated that Resident #1's RPs believed that CMA A used an abusive technique during medication administration. ADM stated that he saw the CMA A used a forceful technique during medication administration and threw a blanket on Resident #1's face. He stated that if staff used force during medication administration, the potential risk to residents could lead to different bodily injuries. The incident with throwing the blanket on Resident #1's head could lead to bad outcome to Resident #1: physical and psychological. He stated that the facility initiated ANE investigation immediately, Resident #1 was monitored, and assessed promptly. He stated that per nursing assessment, Resident #1 was not in physical or psychological distress. He stated that CMA A was employed at this facility for 10 years with no prior counseling or similar allegations. He stated that he interviewed other residents who received medications from CMA A and no report of similar interactions were made to him. He stated that, per interviews with other staff members, no reports were made regarding similar interactions between CMA A and residents at this facility. He stated that according to the facility's investigation they determined that the care provided by CMA A did not meet the facility's standards of care. Specifically, CMA A failed to use appropriate techniques while attempting to awaken a cognitively impaired resident medication administration. He stated that he provided an education of ANE immediately, continued monitoring of Resident #1's condition, and Resident #1's care plan was updated. He stated that safe surveys were done with residents and no other residents at the facility voiced concerns regarding ANE. He stated that they interviewed other staff members at the facility (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and nobody observed ANE or ANE behavior with CMA A. During an interview on 07/02/2026 at 5:13 p.m., CMA A stated she worked at the facility for 11 years. She stated she had ANE training every month. CMA A stated she learned about different types of abuse and neglect like physical, psychological, and verbal. She stated that she had never been involved in ANE before and after that incident. She stated Resident #1 could not communicate and sometimes did not want to take her medication. She stated she asked CNAs in the memory unit to get residents out of bed so she could administer medications to them while they were up and awake, but they frequently didn't do that. CMA A stated she was behind on medication pass that day and a lot of residents were still in bed sleeping, so she tried to wake Resident #1 and after Resident #1 did not wake up, she used a little more forceful technique than she intended pulling her chin down to swallow medication. She stated she felt burned out with so many residents on her case load and required time frame for medication administration. She stated sometimes she could not even go to the bathroom and could not provide quality care to residents with the work load she had. She stated she did not say anything about her frustration to nurses or administration as everybody was expected to complete their work and she just tried to do her work. She stated she could not believe she could do what she did (throw the blanket over Resident #1's head) as it was not her character as she cared about residents. Record review of the facility's policy on ANE, dated 08/15/2022, reflected It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury.intimidation, or punishment with resulting physical harm, pain or mental anguish. Record review of the facility's, undated, policy on Administering Medication to Sleeping or Confused Residents reflected the following techniques: Gentle awaking, use gentle stimulation, allow time, assess readiness, document and return. If resident is sleeping soundly and the medication is not time sensitive, it is often safer to let them sleep and after attempt to administer the dose later. Always document the refusal or delay according to facility protocol. Respect the right to refuse.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure CMA A and CMA H accurately documented Resident #1's medications on 06/19/2026, 06/20/2026 and 06/21/2026. This failure could place residents at risk of medication error or not receiving the intended therapeutic benefit of their medication and delayed healing. Findings include: Record review of Resident #1's care plan, dated 05/14/2026, reflected the problem: [Resident #1] is dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits with indicated interventions: all staff to converse with [Resident #1] while providing care, and reflected the problem: The [Resident #1] has impaired cognitive function related to dementia with indicated interventions: use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Provide the resident with necessary cues, reorient and supervise as needed. Record Review of Resident #1 admission record, dated 07/02/2026, reflected an 86-years-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included atherosclerotic heart disease without angina pectoris (plaque buildup in heart arteries that reduces blood flow but doesn't cause chest pain), vascular dementia (damaged or blocked blood vessels restrict oxygen and nutrients to the brain which cases a decline in thinking skills), depression (a serious mood disorder that causes persistent sadness, loss of interest, and physical fatigue), anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable worry and fear), and need for assistance with personal care. Record review of Resident #1's significant change in status MDS, dated [DATE], reflected a BIMS score of 2, which indicated severe cognitive impairment. Record review on Resident #1 family member's complaint, dated 06/25/2026 and revised on 06/28/2026, reflected: On these same mornings 19th, 20th and 21st, Resident #1 did not receive any morning medications in the room. On the 19th Med Tech came in and took her blood pressure shortly after 7 a.m. but never saw meds given. Record review of written statement of CMA H, dated 6/29/2026, reflected CMA H on June 21, 2026, at approximately 8:03 a.m., Resident #1 was in bed at the time of medication administration. I did not administer the medication while the resident was asleep or disturb the resident due to previous behavioral disruptions that have occurred when she has been awakened from sleep. Therefore, her medication is typically administered after she wakes up or at mealtimes. This information was not documented on Resident #1's MAR. Record review of an undated note from CMA A, reflected on 06/15/26 I went into the room to pass medication to Resident #1. When I arrived in the room, the resident was asleep. I tried to wake her by rubbing her shoulder and then gently patting her on the head. She was not fully awake. I then tried to open her mouth by pressing down on her chin. My intention was to wake her and give medication. Record review of nursing progress notes for Resident #1, dated 06/19/2026, 06/20/2026, and 06/21/2026 did not indicate that Resident #1 did not receiving medications on those days. Record review of Resident #1's Medication administration audit report, dated 07/02/2026, reflected Resident #1's medications scheduled for 7 a.m.: Sertraline HCl oral tablet 100 mg - give 1 tablet by mouth one time a day for depression, Docusate Sodium oral tablet 100 mg - give 1 tablet by mouth two time a day for constipation, omeprazole oral tablet delayed release 20 mg -give one table by mouth one time a day for GERD (gastroesophageal reflux disease - a chronic digestive disorder occurring when stomach acid repeatedly flows back up into the esophagus [the tube connecting your mouth and stomach]), Depakote Sprinkles oral capsule delayed release sprinkle 125 mg. Give 4 capsule by mouth three times a day for dementia behaviors. Carvedilol oral tablet 6.25 mg give 1 tablet by mouth two times a day for HTN (hypertension - high blood pressure). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Polyethylene glycol 3350 oral powder 17 gm/scoop - give 1 scoop by mouth one time a day for constipation, and lorazepam oral tablet 0.5mg - give 1 tablet by mouth two times a day for restlessness were administered on 06/19/2026 at 07:07 a.m. and documented on 06/19/2026 at 7:09 a.m. by CMA A and on 06/20/2026 documented administration of same medications at 07:38 a.m. and documentation on 07:39 a.m. and on 06/21/2026 document administration on 08:03 a.m. and documentation at 08:03 a.m. by CMA H. Attempted interview with CMA H on 07.02.2026 at 2:43 p.m. was unsuccessful. During an interview on 07/02/2026 at 2:47 p.m., RN D stated she did not get any report during her shifts from CMAs about medications that were administered late or not administered to Resident #1 or any other residents. She stated per medication administration policy, medications should be administered first and not after documenting medication administration. During an interview on 07/02/2026 at 2:21 p.m., LVN E stated she assisted Resident #1 on occasions even though she was assigned to Resident #1 as she was assigned to the other side of 100 hallway on the memory unit, but she observed her in the dining room without any signs of distress apparent to her. She stated medication administration should be documented after medication administered to residents and not before. The negative effect of this to residents could be not accurate documentation and possible medication errors: not receiving medication if refused and administration of medication was already recorded. During an interview on 07/02/2026 at 3:21 p.m., LVN G stated no CMAs reported to her that medication was not administered to Resident #1. She stated according to facility medication administration policy, medication administration should be documented afterwards and not before. She stated CMAs were supposed to notify charge nurses regarding missed or delayed medication administration and charge nurses could attempt to administer medications to residents and notify the physician and RPs regarding missed medications. She stated that CMAs did not notify her about medications were administered later and documentation was done before administration of medications. During an interview on 07/02/2026 at 3:33 p.m., CMA B stated she worked at this facility for one year. She stated she had the medication administration training a few days ago. She stated CMAs and nurses should document the medication administration after administration and not before. CMA B stated if residents did not take medication, she should document it in their electronic medication administration records and notify the nurse. She stated she did not see any signs of ANE in Resident #1 and any other residents. She stated she gave medications to Resident #1 when she was up and awake. She stated that residents who were asleep needed to be awaken gently and not forced to take their medications. During an interview on 07/02/2026 at 3:58 p.m., the DON stated Resident #1's RP contacted her and informed her Resident #1 did not receive her medication on certain days. She stated she spoke to medication aides which included CMA A and they informed her she documented medication administration when she popped that medication, but she administered it to Resident #1 later when this resident got up and was taken to the dining room. The DON stated according to their policy on medication administration, ordered medication should be administered first and documented after it was administered to residents. During an interview on 07/02/2026 at 4:10 p.m., the ADM stated he worked at the facility for 7 years. He had training on medication administration sometimes during last year. He stated that it was not his area of expertise but he knew the administration of medications should be first and documentation afterwards. He stated the potential risk to residents could be not accurate administration of medication and documentation. ADM stated that per his interview with CMA A, the medications were administered to Resident #1. He stated that they did not have any witnesses to those administrations. During an interview on 07/02/2026 at 5:13 p.m., CMA A stated she worked at the facility for 11 years. She stated she was trained in medication administration policy and knew about proper medication administration post administration of medication to residents and not before. She stated she crushed routine ordered medications for Resident #1 and mixed them with ensure drink for Resident #1and sometimes she took some of medications but not all of them and she did not know what medications she took and what she didn't, so she documented all of them. Record review of Certified Medication Aide job (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description, reflected the certified medication aide will prepare, administer, and document prescribed medication per protocol. Administers prescribed medications and treatments as defined by state regulations in accordance with company policy and procedure. Reports to charge nurse and documents reasons prescribed drugs are not administered Record review of the facility's Medication administration policy, dated 10/24/2022, reflected: 14. Administer medication as ordered in accordance with manufacturer specification. 17. Sign medication administration record after medication administered. 19. Report and document any adverse side effects or refusals. Record review of camera recording, dated 06/19/2026, 06/20/2026, and 06/21/2026, did not show continuous recording of Resident #1, it was activated by movement. The time stamps between 06:00 a.m. and 9:00 a.m. on 06/19/2026, 06/20/2026, and 06/21/2026 did not reflect medication administration to Resident #1.