STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676266	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longhorn Village	12001 Longhorn Parkway Austin, TX 78732

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately to the administrator of the facility and to the State Survey Agency, for one Resident (Resident #1) of three residents reviewed for abuse/neglect. The facility failed to report to the administrator of the facility and to the State Agency that Resident #1's family on 02/04/25 had alleged that a CNA had pinched and been rough with Resident #1. This failure could place residents at risk for continuation or repetition of abuse, or abuse becoming more widespread. Findings included: Review of Resident #1's MDS reflected that Resident #1 was a [AGE] year old female resident admitted to the facility on [DATE] with diagnoses in part including metabolic encephalopathy (a change in how the brain works due to an underlying condition that can result in confusion, memory loss, or loss of consciousness), heart failure (the heart doesn't pump blood as well as it should), hypertension (elevated blood pressure), dysphagia (difficulty swallowing), and pneumonia (infection in the lungs). Resident #1's BIMS score was six, indicating severe cognitive impairment. In an interview and observation on 03/04/25 at 3:05 pm, Resident #1's family stated a while back (she did not know the date), she and her mother were eating lunch in the dining room and her mother pointed at a CNA and stated that the CNA had been rough with her and had pinched her. The family reported that an unknown person in the dining room (not facility staff) told her it was true. Resident #1's family reported that she notified the DON at the time and thought the aide may have been fired. Resident #1 opened her eyes but did not respond to interview questions. In a review of the facility grievance log from December 2024 through February 2024, a grievance dated 02/04/25 and signed by the AIT stated that a family member, reported that [CNA A] has been rough with her [Resident #1], per patient. When moved to the dining room today her mother said, don't pinch me and the resident sitting across from her said she did pinch her. The action plan included to, remove the resident from the CNA's assignment and do not assign the resident to the [CNA A] permanently. (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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(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 - Few	A review of TULIP reflected no events reported for this allegation between 10/04/24 and 02/03/25 indicating the allegation of abuse was not reported to Health and Human Services. A review of Resident 1's progress notes for the week surrounding 02/04/25 (date of grievance) revealed no progress notes or skin or other assessments regarding the reported incident. In an interview on 03/05/25 at 9:05 am, CNA A reported that about 1.5 months ago she was informed by the DON that Resident #1's family had reported that Resident #1 had reported that she was rough with her during care and had pinched her while in the dining room. CNA A reported the DON informed her she would no longer be working with Resident #1. She denied having pinched or been rough when providing care to Resident #1. In an interview on 03/05/25 at 10:14 am, DON stated that she completed the investigation in February 2025 in which Resident #1's family mentioned to her that someone in the dining room had stated that CNA A had pinched Resident #1. She stated she interviewed CNA A who denied having pinched or been rough with Resident #1 and reported others were present in the dining room. She stated they conducted a skin assessment, she believed it should be in the electronic medical record, and Resident #1 did not have any injuries. She stated Resident #1's family did not want CNA A to work with Resident #1 anymore. She reported that the facility does not usually do progress noted on this type of incident because it was in-house. Instead, they do a grievance and that was what she did. She reported that CNA A was not suspended but was removed from Resident #1's care. The DON reported that, If there is an allegation, we talk, interview, and investigate, and if there is really an abuse, we report it. In this case we did not report it to the state because we did not find it to be abuse. If we suspect abuse, we report it to the administrator. The DON stated she reported the allegation to the administrator the next morning in report. In an interview on 03/05/25 at 10:49 am, NP B stated that about a month ago she was made aware that there was an allegation of roughness by a CNA with Resident #1. She stated she did not know what that roughness entailed or where the incident might have occurred. She stated she was never informed of any allegation that Resident #1 was pinched. She stated she was told there was no injury, and she does not remember any injuries but that she did not need to do an assessment or any documentation of the incident. In an interview on 03/05/25 at 10:57 am, the AIT stated that Resident #1's family told the DON on 02/04/24 that at lunch Resident #1 had told her that CNA A had pinched her, and she had completed a grievance report. She reported the DON did her investigation with the resident and the aid. She stated that she had just had a meeting with the administrator and now realizes the incident needed to have been reported to the state. She reported that everyone was responsible for reporting abuse but that the Director or the Administrator do the state reports. She stated the risk of not reporting an allegation of abuse is the risk of it happening again or being widespread and affecting other residents. She stated CNA A is being suspended today (03/05/25) pending investigation outcome. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/25 at 11:25 am, the ADM stated she just found out about the situation with Resident #1. She reported she was not notified of the allegation of abuse. She stated she heard within the past hour that the Resident #1's family member had reported to the AIT, that Resident #1 head told her family member that she had been pinched and in passing there was another resident that said yes, the CNA did pinch Resident #1. She stated she was told that the DON did a skin assessment and the daughter requested to not have the CNA as a caregiver. ADM reported she was upset with her team and had just educated them on abuse, what are the types, when and who to report abuse to. She stated that she contacted the Director who also stated she was not notified of the incident. She reported the team should have notified one of us. She stated if she had been notified, she would have asked if the skin assess was complete, sent CNA A home pending investigation, reinterviewed the resident, and completed a self-report for the state. ADM reported the DON told me she did the skin assessment but that she did not document it. ADM stated the risk of an allegation of abuse not being reported is that if it truly happened it could continue to happen or could happen to other residents. She stated that the alleged perpetrator, CNA A, has been placed on suspension immediately pending outcome investigation. In an interview on 03/05/25 at 11:59 am, the Director stated that today (03/05/25) was the first time that she had heard that Resident #1 was pinched, and she was currently doing a self-report. She stated she would have expected the staff to notify her at the time of the incident. She reported if she had been notified, she would have reported it within the appropriate timeframe to the state and started the internal investigation as pinching was a form of physical abuse. She reported that when there was an allegation of physical abuse a physical assessment should be documented in the electronic medical record. She stated the risk of failing to report an allegation of abuse would be potential further risk for abuse. Review of TULIP records noted this allegation was received by Health and Human Services as a facility self-report on 3/5/2025 at 12:45 PM. This allegation of abuse was investigated by this surveyor and there was not sufficient evidence to substantiate this allegation of abuse regarding pinching and/or roughness. No injury or trauma to Resident #1 was determined. The facility policy dated April 2014 and titled, 2 EXHIBIT C ABUSE PREVENTION POLICY stated that, Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment and that, Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. The document notes that, Any allegations of abuse will be reported to the Administrator immediately and to the State Department of Health and the resident's representative as soon as possible within 24 hours. The policy also stated, The administrator or designee will review the report. The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the State Department of Health within five working days of the reported incident.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on interview and record review, in response to an allegation of abuse, the facility failed to have evidence that all alleged violations were thoroughly investigated, and to prevent further potential abuse while the investigation was in progress for one (Resident #1) of three residents reviewed for abuse. The facility failed to thoroughly investigate an allegation that a staff member had been rough with and pinched Resident #1 and failed to suspend the alleged perpetrator on 02/04/25. This failure could place resident's at risk for continued abuse, unidentified injuries or trauma, and the spread of abuse to other residents. Findings included: Review of Resident #1's MDS reflected that Resident #1 was a [AGE] year old female resident admitted to the facility on [DATE] with diagnoses in part including metabolic encephalopathy (a change in how the brain works due to an underlying condition that can result in confusion, memory loss, or loss of consciousness), heart failure (the heart doesn't pump blood as well as it should), hypertension (elevated blood pressure), dysphagia (difficulty swallowing), and pneumonia (infection in the lungs). Resident #1's BIMS score was six, indicating severe cognitive impairment. In an interview and observation on 03/34/25 at 3:05, Resident #1's family reported a while back (she did not know the date), she and her mother were eating lunch in the dining room and her mother pointed at a CNA and stated that the CNA had been rough with her and had pinched her. The family reported that an unknown person in the dining room (not facility staff) told her it was true. Resident #1's family reported that she notified the DON at the time and thought the aide may have been fired. Resident #1 opened her eyes but did not respond to interview questions. In a review of the facility grievance log from December 2024 through February 2024, a grievance dated 02/04/25 and signed by the Administrator in Training (AIT) stated, daughter reported that [CNA A] has been rough with her mom, per patient. When moved to the dining room today her mother said, don't pinch me and the resident sitting across from her said she did pinch her. The action plan included to, remove the resident from the CNA's assignment and do not assign the resident to the [CNA A] permanently. A review of TULIP reflected no events reported for this allegation between 10/04/24 and 02/03/25 indicating the allegation of abuse was not reported to HHS. A review of Resident 1's progress notes for the week surrounding 02/04/25 (date of grievance) revealed no progress notes regarding the reported incident. There were no injury assessments, trauma assessments, or skin assessments. These progress notes did not indicate that the nurse practitioner, the physician, or the family had been notified of the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/25 at 9:05 am, CNA A reported that about 1.5 months ago she was informed by the DON that Resident #1's family had reported that Resident #1 had reported that she was rough with her during care and had pinched her while in the dining room. CNA A reported the DON informed her she would no longer be working with Resident #1. She denied having pinched or been rough when providing care to Resident #1. In an interview on 03/05/25 at 10:14 am, DON stated that she completed the investigation in February 2025 in which Resident #1's family mentioned to her that someone in the dining room had stated that CNA A had pinched Resident #1. She stated she interviewed CNA A who denied having pinched or been rough with Resident #1 and reported others were present in the dining room. She stated they conducted a skin assessment, she believed it should be in the electronic medical record, and Resident #1 did not have any injuries. She stated Resident #1's family did not want CNA A to work with Resident #1 anymore. She reported that the facility does not usually do progress noted on this type of incident because it was in-house. Instead, they do a grievance and that was what she did. She reported that CNA A was not suspended but was removed from Resident #1's care. The DON reported that, If there is an allegation, we talk, interview, and investigate, and if there was really abuse, we report it. In this case we did not report it to the state because we did not find it to be abuse. If we suspect abuse, we report it to the administrator. The DON stated she reported the allegation to the administrator the next morning in report. In an interview on 03/05/25 at 10:49 am, NP B reported that about a month ago she was made aware that there was an allegation of roughness by a CNA with Resident #1. She stated she did not know what that roughness entailed or where the incident might have occurred. She stated she was never informed of any allegation that Resident #1 was pinched. She stated she was told there was no injury, and she does not remember any injuries but that she did not need to do an assessment or any documentation of the incident. In an interview on 03/05/25 at 10:57 am, the AIT reported that Resident #1's family told the DON on 02/04/24 that at lunch Resident #1 had told her that CNA A had pinched her, and she had completed a grievance report. She reported the DON did her investigation with the resident and the aid. She stated that she had just had a meeting with the administrator and now realizes the incident needed to have been reported to the state. She reported that everyone is responsible for reporting abuse but that the Director or the Administrator do the state reports. She stated the risk of not reporting an allegation of abuse is the risk of it happening again or being widespread and affecting other residents. She stated CNA A is being suspended today (03/05/25) pending investigation outcome. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/25 at 11:25 am, the ADM reported she just found out about the situation with #. She reported she was not notified of the allegation of abuse. She stated she heard within the past hour that the daughter reported to the AIT, that Resident #1's daughter had been pinched and in passing there was another resident that said yes, the CNA did pinch her. She stated she was told that the DON did a skin assessment and the daughter requested to not have the CNA as a caregiver. She reported she was upset with her team and had just educated them on abuse, what are the types, when and who to report abuse to. She stated that she contacted the Director who also stated she was not notified of the incident. She reported the team should have notified one of us. She stated if she had been notified, she would have asked if the skin assess was complete, sent CNA A home pending investigation, reinterviewed the resident, and completed a self-report for the state. ADM reported the DON told me she did the skin assessment but that she did not document it. She reported the risk of not completing an assessment would be that an injury might not be identified. ADM stated the risk of an allegation of abuse not being reported is that if it truly happened it could continue to happen or could happen to other residents. She stated that the AP, CNA A, has been placed on suspension immediately pending outcome investigation. In an interview on 03/05/25 at 11:59 am, the Director stated that today (03/05/25) was the first time that she had heard that Resident #1 was pinched, and she was currently doing a self-report. She stated she would have expected the staff to notify her at the time of the incident. She reported if she had been notified, she would have reported it within the appropriate timeframe to the state and started the internal investigation as pinching is a form of physical abuse. She reported that when there is an allegation of physical abuse a physical assessment should be documented in the electronic medical record and that not doing this could result in an injury being missed. She stated the family and the nurse practitioner and/or the physician should be notified. She stated the risk of failing to report an allegation of abuse would be potential further risk for abuse. Review of TULIP records noted this allegation was received by Health and Human Services as a facility self-report on 3/5/2025 at 12:45 PM. This allegation of abuse was investigated by this surveyor and there was not sufficient evidence to substantiate this allegation of abuse regarding pinching and/or roughness. No injury or trauma to Resident #1 was determined. The facility policy dated April 2014 and titled, 2 EXHIBIT C ABUSE PREVENTION POLICY stated that, Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment and that, Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. The policy also stated, The administrator or designee will review the report. The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the State Department of Health within five working days of the reported incident. The policy also stated, All incidents will be documented, whether or not abuse occurred, was alleged or suspected. This policy further stated, Employees of this community who have been accused of abuse, neglect, or mistreatment will be immediately suspended until the results of the investigation have been reviewed by the administrator or designee.