STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676487	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Parmer	13800 N Fm 620 Rd Sb Austin, TX 78717

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, ensure that all alleged violations are reported to the state survey agency immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse for one (1) of five (5) residents reviewed for abuse and neglect. (Resident #1).The facility failed to report an alleged abuse incident reported by Resident #1 on 06/19/2025 to the State Agency when Resident#1 alleged CNA B pushed her. This deficient practice placed all residents at risk of harm from abuse due to not having a thorough investigation done for an alleged abuseFindings Include: Record review of Resident #1's face sheet, dated 07/15/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hypertension (high blood pressure), fall on the same level from slipping, muscle weakness, unsteady to the feet, history of falling, traumatic subdural Hemorrhage (a type of traumatic brain injury (TBI) where blood collects under the dura mater, the outer membrane covering the brain, due to a head injury) without loss of consciousness subsequent encounter. Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 10 indicating moderate cognitive impairment. Review of Resident #1's care plan initiated 05/30/2025 reflected Resident #1 had actual/potential decline in her ability to perform her activities of daily living, bowel/bladder incontinence, and need for assistance with transfers/toileting related to impaired mobility secondary to weakness and debility (physical weakness, especially as a result of illness.Most of the cases presented with general debility, muscle weakness, and weight loss.)Review of CNA B's written statement dated 06/19/2025 reflected: June 19, 2025 3:47 am Patient in [xx] had call light on upon entering the room the patient was sitting in her wheelchair and asked if I could help her unlock her brakes. I asked her why she didn't call before she transferred to the chair. She stated that she's not a 2-year-old and should not have to ask for permission to go to the bathroom. I explained to her the safety issue of calling before she transferred to her chair. She then stated that you've been a bitch since day one and won't let me do anything on my own. I proceeded to help her with her brakes and take her to the restroom, she refused to let me help her toilet. I explained to her that her chair is not locked and it's not safe for her to do this alone. I locked her chair and let her toilet herself while I stood outside of the restroom. I noticed she was struggling to pull up her underwear so I asked her if I could help with that, she then yelled at me to get away from her she does not need my help. She then accused me of throwing her up against the wall. I then exited the room and alerted the nurse of what the patient was saying. [room #] Statement [CNA B].Review of LVN A's written statement dated 06/19/2025 reflected: To: Abuse Coordinator Re: Statement regarding patient allegation Patient: [Resident #1]6/19/25 This date 6/19/25 this nurse called into the patient's, [Resident #1] room by [CNA B]. This nurse entered room, observed [CNA B] standing by restroom door, and patient [Resident #1] awake, sitting in her wheelchair by the bed, no s/s of distress. [CNA B] informed this nurse that patient stated CNA had pushed her. This nurse asked CNA B to leave room, then asked patient to tell me what happened. Patient verbalized that while transferring to the toilet from the wheelchair, CNA B pushed her left shoulder against the wall. This nurse asked if I may check her for injury, patient agreeable. No visible sign of injury noted to back, shoulders or face. ROM per baseline, patient denied pain. This nurse reassured patient that the CNA would not return to room, and assisted patient back into bed safely, bed placed in low position, fall precautions in place, call light within reach. This nurse immediately notified abuse coordinator and spoke with DON. [LVN A]During an interview on 07/15/2025 at about 2:20 pm, the DON stated there was an allegation incident of abuse regarding Resident #1. The DON stated CNA B went to assist Resident #1 in her room on the overnight shift, CNA B did not touch Resident #1, and Resident #1 accused CNA B of pushing her. The DON stated LVN A notified her and both LVN A and CNA B left written statements.During an interview on 07/15/2025 at about 2:32 pm, LVN A stated on the morning of 06/19/2025 Resident #1 alleged that CNA B pushed her. LVN A stated CNA B called her [LVN A] to inform her that Resident #1 alleged she had pushed her. LVN A said she asked the CNA to leave the room while she spoke with Resident #1. LVN A stated Resident #1 stated CNA B had pushed her. LVN A stated she assessed Resident #1 and there was no evidence of injuries. LVN A stated she helped Resident #1 out of the restroom. LVN A stated she and CNA B wrote statements for the abuse coordinator, and she reported the incident immediately. During an interview on 07/15/2025 at about 3:13 pm the Administrator stated he had just found out about the incident today 07/15/2025 regarding

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for one (1) of five (5) residents reviewed for abuse and neglect. (Resident #1).The facility failed to thoroughly investigate an alleged abuse incident reported by Resident #1 on 06/19/2025 when Resident #1 alleged being pushed by CNA B. This deficient practice placed all residents at risk of harm from abuse due to not having a thorough investigation done for an alleged abuse.Findings Include: Record review of Resident #1's face sheet, dated 07/15/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hypertension (high blood pressure), fall on the same level from slipping, muscle weakness, unsteady to the feet, history of falling, traumatic subdural Hemorrhage (a type of traumatic brain injury (TBI) where blood collects under the dura mater, the outer membrane covering the brain, due to a head injury) without loss of consciousness subsequent encounter. Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 10 indicating moderate cognitive impairment. Review of Resident #1's care plan initiated 05/30/2025 reflected Resident #1 had actual/potential decline in her ability to perform her activities of daily living, bowel/bladder incontinence, and need for assistance with transfers/toileting related to impaired mobility secondary to weakness and debility (physical weakness, especially as a result of illness.Most of the cases presented with general debility, muscle weakness, and weight loss.)Review of CNA B's written statement dated 06/19/2025 reflected: June 19, 2025 3:47 am Patient in [xx] had call light on upon entering the room the patient was sitting in her wheelchair and asked if I could help her unlock her brakes. I asked her why she didn't call before she transferred to the chair. She stated that she's not a 2-year-old and should not have to ask for permission to go to the bathroom. I explained to her the safety issue of calling before she transferred to her chair. She then stated that you've been a bitch since day one and won't let me do anything on my own. I proceeded to help her with her brakes and take her to the restroom, she refused to let me help her toilet. I explained to her that her chair is not locked and it's not safe for her to do this alone. I locked her chair and let her toilet herself while I stood outside of the restroom. I noticed she was struggling to pull up her underwear so I asked her if I could help with that, she then yelled at me to get away from her she does not need my help. She then accused me of throwing her up against the wall. I then exited the room and alerted the nurse of what the patient was saying. [room #] Statement [CNA B].Review of LVN A's written statement dated 06/19/2025 reflected: To: Abuse Coordinator Re: Statement regarding patient allegation Patient: [Resident #1]6/19/25 This date 6/19/25 this nurse called into the patient's, [Resident #1] room by [CNA B]. This nurse entered room, observed [CNA B] standing by restroom door, and patient [Resident #1] awake, sitting in her wheelchair by the bed, no s/s of distress. [CNA B] informed this nurse that patient stated CNA had pushed her. This nurse asked CNA B to leave room, then asked patient to tell me what happened. Patient verbalized that while transferring to the toilet from the wheelchair, CNA B pushed her left shoulder against the wall. This nurse asked if I may check her for injury, patient agreeable. No visible sign of injury noted to back, shoulders or face. ROM per baseline, patient denied pain. This nurse reassured patient that the CNA would not return to room, and assisted patient back into bed safely, bed placed in low position, fall precautions in place, call light within reach. This nurse immediately notified abuse coordinator and spoke with DON. [LVN A]During an interview on 07/15/2025 at about 2:20 pm, the DON stated there was an allegation incident of abuse regarding Resident #1. The DON stated CNA B went to assist Resident #1 in her room on the overnight shift, CNA B did not touch Resident #1, and Resident #1 accused CNA B of pushing her. The DON stated LVN A notified her and both LVN A and CNA B left written statements.During an interview on 07/15/2025 at about 2:32 pm, LVN A stated on the morning of 06/19/2025 Resident #1 alleged that CNA B pushed her. LVN A stated CNA B called her [LVN A] to inform her that Resident #1 alleged she had pushed her. LVN A said she asked the CNA to leave the room while she spoke with Resident #1. LVN A stated Resident #1 stated CNA B had pushed her. LVN A stated she assessed Resident #1 and there was no evidence of injuries. LVN A stated she helped Resident #1 out of the restroom. LVN A stated she and CNA B wrote statements for the abuse coordinator, and she reported the incident immediately. During an interview on 07/15/2025 at about 3:13 pm the Administrator stated he had just found out about the incident today 07/15/2025 regarding Resident #1