STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455599	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehabilitation and Skilled Nursing C	2806 Real St Austin, TX 78722

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 interviews and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is a deterioration in health, mental or psychosocial s tatus in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 7 residents reviewed for physician notification, in that: The facility failed to notify Resident #1's physician when she developed a rash on 07/26/2025 and no skin assessment was conducted for Resident #1 on 07/26/2025 after the rash was found and there was no notification to physician to obtain orders for treatment. The facility failed to notify Resident #1's family when she refused showers regularly. Resident #1 was admitted on [DATE], discharged on 08/05/2025, and refused a shower on 07/18/2025, 07/23/2025, 07/25/2025, and on 08/01/2025. Resident #1 was bathed twice during her stay at the facility. This failure could result in decreased continuity of care, and/or a delay in treatment or services. Findings included: Review of Resident #1 face sheet reflected a [AGE] year-old female admitted on [DATE] and discharged on 08/05/2025 with diagnoses of osteomyelitis (bone infection), encounter for orthopedic aftercare following surgical amputation (need for care and monitoring after amputation), encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (need for care and monitoring on outer layers of skin), acquired absence of right leg below knee(amputation of leg below knee), phantom limb syndrome with pain (condition where individuals experience pain in a limb that has been removed), unspecified dementia (general loss of intellectual abilities impacting memory and other cognitive functions), depression (mood disorder characterized by persistent feelings of sadness and loss of interest in activities that were once enjoyable), and adjustment disorder(condition where a person experiences emotional or behavioral symptoms in response to a stressful life event or change). Review of Resident #1 admission MDS dated [DATE] reflected BIMS score of 10 which indicated moderate cognitive impairment. Further review reflected Resident #1 sometimes felt lonely or isolated from those around her. Review reflected Resident #1's current behavior status, care rejection or wandering was worse than previous assessments. Review of section F reflected it was very important for Resident #1 to have family involved in discussions about her care. Review of section m reflected resident was at risk of developing pressure ulcers with only skin alterations as surgical wounds. Review of Resident #1 care plan dated 07/24/2025 reflected Resident #1 did not let staff assist her and preferred wanted family to provide her care. Interventions included to explain or reinforce why behavior or inappropriate or unacceptable to Resident #1. Further review reflected Resident #1 has impaired cognitive function or impaired through processes related to dementia with interviews to communicate with the resident/family/caregivers regarding residents' capabilities and needs. Review of care plan dated 08/06/2025 reflected Resident #1 was at risk for impaired skin integrity related to impaired mobility and incontinence. Interventions included conducted skin inspections weekly and as needed and document findings. Review of shower hall schedule reflected Resident #1 had showers scheduled on Tuesday, Thursday and Saturdays. Review of POC response history for Resident #1 reflected Resident #1 refused a shower on 07/18/2025, 07/23/2025, 07/25/2025 and on 08/01/2025. Further review reflected Resident #1 was bathed twice during her stay at the facility and had a bed bath on 07/21/2025 and a shower on 07/30/2025. Review of Resident #1 dated 07/21/2025 H&P reflected Resident #1 was alert and oriented x 1-2 (oriented to self and family) at baseline and disoriented to place, time and situations which was also baseline. Resident was overwhelmed by below knee amputation and inability to ambulate. Review of Resident #1 nursing progress notes dated 07/18/2025 reflected Resident #1 knows her name and place, but does not know the date, time or day. Further review of progress note dated 07/26/2025 by RN A reflected Resident's back was found to be covered in significant rash by resident's (family member) today. During a discussion between floor CNA and RN A and FM, it was determined that the resident had been refusing showers. Review of progress note dated 07/27/2025 reflected Resident #1 was offered a shower and initially refused, staff provided education on importance of showering as Resident #1 was observed with rashes to her right flank area and back. Resident #1 verbalized understanding and declined shower but agreed to bed bath. Resident #1 received a bed bath and treatment nurse was made aware. Review of progress notes reflected Resident #1's family was not notified prior to 07/26/2025 that she refused showers and bed baths. Review also reflected Resident #1's family was not notified of her shower refusal on 08/01/2025. Review of Resident #1 progress notes reflected

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 4 (Resident #3, Resident #4, Resident #5 and Resident #6) of 7 residents reviewed for environment. The facility failed to ensure Resident #3, Resident #4, Resident #5 and Resident #6's linens were free of tears, free of holes or not stained on 08/07/2025. These failures placed residents at risk of discomfort, embarrassment and diminished quality of life. Findings included:Review of Resident #3 face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Wernicke's encephalopathy (neurological condition caused by vitamin b1 deficiency), unspecified dementia (general loss of intellectual abilities impacting memory and other cognitive functions) and mood disorder (mental health condition characterized by significant disturbances in a person's emotional state). Review of Resident #3 quarterly MDS dated [DATE] reflected a BIMs score of 11 which indicated mildly impaired cognition. Review of Resident #3 care plan dated 03/13/2025 reflected Resident #3 was dependent on staff for meeting emotional, intellectual, physical and social needs. Observation on 08/07/2025 at 9:37 AM revealed Resident #3's sheets had a hole in it. Resident #3 was not in her room at this time. During an observation and interview on 08/07/2025 at 2:10 PM, Resident #3 stated that she did not notice any holes in her blankets or sheets. Resident stated that her linen looked dirty now, but it did not bother her. Resident's bedding was observed with food crumbs. Review of Resident #4's face sheet reflected an [AGE] year-old female admitted on [DATE] with diagnoses of schizophrenia (severe mental health condition that significant impact's a person's ability to think, feel and behave clearly), unspecified dementia (general loss of intellectual abilities impacting memory and other cognitive functions), and major depressive disorder (serious mental health condition characterized by persistent feelings of sadness). Review of Resident #4's quarterly MDS dated [DATE] reflected a BIMS score of 9 which indicated moderate cognitive impairment. Review of Resident #4's care plan dated 10/11/2021 reflected communication problem related to dementia and schizophrenia with intervention to anticipate and meet needs. During an interview an observation on 08/07/2025 at 1:01 PM, revealed a small hole observed in Resident #4's sheets. Resident #4 stated that there was a hole in her sheet and that it did not make her feel very good. She stated she sometimes has a hole and depending on the time-of-day staff will give her another blanket or sheet. Review of Resident #5 face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of major depressive disorder (serious mental health condition characterized by persistent feelings of sadness), and unspecified dementia (general loss of intellectual abilities impacting memory and other cognitive functions). Review of Resident #5 annual MDS dated [DATE] reflected a BIMS of 0 which indicated a severe cognitive impairment. Review of Resident #5 care plan dated 06/03/2024 reflected Resident #5 had impaired cognitive function and through process related to dementia. During observation an attempted interview on 08/07/2025 at 1:00 reflected a small hole in Resident #5's sheets. Resident was unable to answer questions due to cognition. Review of Resident #6 face sheet reflected a [AGE] year-old mane admitted on [DATE] with diagnoses of vascular dementia (cognitive difficulty with reasoning and judgement caused by an impaired supply of blood to the brain), type 2 diabetes and chronic kidney disease. Review of Resident #6 annual MDS dated [DATE] reflected BIMS score of 5 which indicated severe cognitive impairment. Review of Resident #6 care plan dated 05/08/2023 reflected Resident #6 had an impaired cognitive function related to multiple strokes. Review reflected Resident #6 had communication problem related to slurring, weak or absent voice with intervention to anticipate and meet needs. Observation on 08/07/2025 at 9:26 AM revealed Resident #6's bed was made with grey blanket with tattered edges. Resident was at an appointment and unable to be interviewed. Observation of clean linen on 08/07/2025 at 12:45 PM, reflected beige blanket with tattered edges and folded white flat sheet with a yellow stain. During an interview on 08/07/2025 at 1:24 PM, CNA E stated that she has not seen linen with any holes and if they were observed they would be sent back to laundry. CNA E stated it was not okay for residents to have blankets that were tattered or with holes. CNA E stated she was not aware Resident #6's blanket was tattered. During an interview on 08/07/2025 at 1:33 PM, CNA F stated that he has seen linen with holes, but if he saw them he threw them away. CNA F stated it was not okay for a resident's blanket to be in a tattered condition. During an interview on 08/07/2025 at 2:12 PM, CNA I stated she has not observed linen with holes or stains. She stated if she did observe holes or stains, she would change the linen. During an interview on 08/07/2025 at 2:19 PM, LA G stated that if looked at linen after they

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of seven residents reviewed for quality of care. The facility failed to assess Resident #1 and report a new rash to the physician on 07/26/2025. There were no orders added for rash/skin treatments from 07/26/2025 to 08/07/2025 for Resident #1. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization. Findings included: Review of Resident #1 face sheet reflected a [AGE] year-old female admitted on [DATE] and discharged on 08/05/2025 with diagnoses of osteomyelitis (bone infection), encounter for orthopedic aftercare following surgical amputation (need for care and monitoring after amputation), encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (need for care and monitoring on outer layers of skin), acquired absence of right leg below knee(amputation of leg below knee), phantom limb syndrome with pain (condition where individuals experience pain in a limb that has been removed), unspecified dementia (general loss of intellectual abilities impacting memory and other cognitive functions), depression (mood disorder characterized by persistent feelings of sadness and loss of interest in activities that were once enjoyable), and adjustment disorder(condition where a person experiences emotional or behavioral symptoms in response to a stressful life event or change). Review of Resident #1 admission MDS dated [DATE] reflected BIMS score of 10 which indicated moderate cognitive impairment. Further review reflected Resident #1 sometimes felt lonely or isolated from those around her. Review reflected Resident #1's current behavior status, care rejection or wandering was worse than previous assessments. Review of section F reflected it was very important for Resident #1 to have family involved in discussions about her care. Review of section m reflected resident was at risk of developing pressure ulcers with only skin alterations as surgical wounds. Review of Resident #1 care plan dated 07/24/2025 reflected Resident #1 did not let staff assist her and preferred wanted family to provider her care. Interventions included to explain or reinforce why behavior or inappropriate or unacceptable to Resident #1. Further review reflected Resident #1 has impaired cognitive function or impaired through processes related to dementia with interviews to communicate with the resident/family/caregivers regarding residents' capabilities and needs. Review of care plan dated 08/06/2025 reflected Resident #1 was at risk for impaired skin integrity related to impaired mobility and incontinence. Interventions included conducted skin inspections weekly and as needed and document findings. Review of Resident #1 orders reflected there was no orders added for rash/skin treatments from 07/26/2025 to 08/05/2025. Review of skin assessments reflected no skin assessment was conducted for Resident #1 on 07/26/2025 after the rash was found. Review of Resident #1 skin assessment dated [DATE] reflected no new skin issues were found. Review of Resident #1 skin assessment dated [DATE] reflected no new skin issues were found. Review of Resident #1 dated 07/21/2025 H&P reflected Resident #1 was alert and oriented x 1-2 (oriented to self and family) at baseline and disoriented to place, time and situations which was also baseline. Resident was overwhelmed by below knee amputation and inability to ambulate. Review of Resident #1 nursing progress notes dated 07/18/2025 reflected Resident #1 knows her name and place, but does not know the date, time or day. Further review of progress note dated 07/26/2025 by RN A reflected Resident's back was found to be covered in significant rash by resident's daughter today. During a discussion between floor CNA and RN A and FM, it was determined that the resident had been refusing showers. Review of progress note dated 07/27/2025 reflected Resident #1 was offered a shower and initially refused, staff provided education on importance of showering as Resident #1 was observed with rashes to her right flank area and back. Resident #1 verbalized understanding and declined shower but agreed to bed bath. Resident #1 received a bed bath and treatment nurse was made aware. Review of progress notes reflected Resident #1's family was not notified prior to 07/26/2025 that she refused showers and bed baths. Review also reflected Resident #1's family was not notified of her shower refusal on 08/01/2025. Review of Resident #1 progress notes reflected NP was not notified that Resident #1 was found with a rash on her back. Review of Resident #1 NP progress note dated 07/29/2025 reflected Resident #1 had some skin irritation to her back per wound care nurse likely to resident refusal to shower. During an interview on 08/07/2025 at 10:49 AM, FM stated that Resident #1 had redness on her back and sores that were bleeding. FM stated that she saw the sores when she visited Resident #1 at the facility. FM stated that she was not