

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2025
NAME OF PROVIDER OR SUPPLIER Heritage Park Rehabilitation and Skilled Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident environment remains as free of accidents and hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #1) reviewed for adequate supervision. The facility failed to ensure Resident #1 was not left unattended on 10/10/2025 at an off-site medical appointment that was an unfamiliar location. Resident #1 had neither appropriate supervision nor arrangements for return transportation. Resident #1 was left alone in an unfamiliar place, with diminished cognition and altered physical ability. An Immediate Jeopardy (IJ) situation was identified on 10/11/2025. While the IJ was removed on 10/14/2025 the facility remained out of compliance at a scope of isolated that is immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk of physical harm due to lack of mobility device, emotional and/or mental distress and feelings of abandonment. Findings included: A review of Resident #1's health records shows that she is a [AGE] year-old woman who was admitted to the facility on [DATE]. She has several health issues, including dorsalgia (back pain), schizophrenia (a mental health disorder affecting thoughts, feelings, and behaviors), and constipation (difficulty in passing stools). Additionally, she suffers from osteoporosis (weakening of bones due to age, with no current fractures), left hip pain, insomnia (trouble sleeping), and visual disturbances (issues with eyesight). Other diagnoses include hypertension (high blood pressure), major depressive disorder (recurrent) characterized by persistent sadness and loss of interest, abnormal weight loss, and dementia (a decline in mental ability). She also has vitamin D deficiency (not enough vitamin D for bone health) and polyosteoarthritis (arthritis affecting multiple joints). Bilateral impacted cerumen (earwax buildup in both ears) may affect her hearing, while frontotemporal neurocognitive disorder impacts her personality and behavior. Furthermore, she has paranoid schizophrenia, hypertensive heart disease (heart problems from high blood pressure, without heart failure), age-related cataracts (clouding of both lenses due to aging), melena (black, tarry stools indicating digestive bleeding), and iron deficiency hemorrhage (bleeding from the anus or rectum). She experiences gastroesophageal reflux disease (GERD), obesity (excess body weight), chronic obstructive pulmonary disease (COPD), kidney stones, abnormalities of gait and mobility (issues with walking), and muscle wasting and atrophy (loss of muscle mass and strength). These conditions affect her overall health and daily functioning. Record review of Resident #1's Resident Care Plan, dated 6/13/2025, reflected Resident #1 had diagnoses which included ADL self-care performance deficit, Dementia (a memory problem), Osteoporosis (bone weakness), and Impaired balance (unsteady or off-balance), Ambulation: The resident was independent to supervised w/ambulation- uses walker. The resident will maintain current level of mobility with propelling in her wheelchair. Record Review of the MDS dated [DATE], reflects Resident# 1 with a BIMS score of 09 that indicated a moderate level of cognitive impairment. Resident marked to use a [NAME] in the Mobility Devices sections of the MDS. Resident # 1 was assessed to not have long or short-term memory problems. Interviewed a Health Center staff member on 10/10/2025, at 7:25pm, she revealed that Resident #1 was found unsupervised outside in a hospital courtyard by a security guard, who reported the situation to hospital staff. They subsequently contacted the facility to inform them that no one was present to accompany or return the resident from her appointment. Record review of facility incident report on 10/11/2025, reflects a head-to-toe assessment that was performed on Resident #1 and no injuries or skin issues were noted. During an interview on 10/11/2025, at 1:28pm, Resident #1 stated, I was told I was supposed to have an appointment. I believe, I was dropped off by a new facility driver. She said she was not frightened but was hungry since she had not eaten breakfast. Interviewed Van Driver C on 10/11/2025, at 2:23pm, he revealed that on the morning of the incident, he arrived at 5:00 AM for a 6:00 AM transport assignment. After confirming the details with an overnight nurse who he does not recall the name of and gave no special instructions, he transported the resident to Health Center A at 5:30 AM. Upon arrival at 5:50 AM, he parked in the designated area, assisted the resident from the vehicle, and watched her enter the building before leaving. Later notified that the appointment was canceled, he returned to retrieve the resident. Later that day he was notified that he was suspended pending investigation. Interviewed the Director of Nursing on 10/11/2025, at 3:23pm, she confirmed that the facility requires staff to accompany residents to off-site appointments when supervision is indicated. The DON acknowledged that the staff involved did not follow this recommendation, which was</p>		