

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  09/20/2023
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for 3 (Resident #20, #65, and #395) of 169 residents reviewed for resident rights and ensure each resident was provided a safe, clean, comfortable, and homelike environment in that:</p> <ol style="list-style-type: none"> <li>1. Staff did not check on and make sure Resident #20 was fully clothed.</li> <li>2. Resident #395's urinal was out in plain sight, emptied, and cleaned.</li> <li>3. Resident #65 repeatedly urinated in resident common areas, threw, and damaged facility property placing residents in an uncomfortable, unsanitary, and non-homelike environment.</li> </ol> <p>These deficient practices placed residents at risk of a decline in their sense of dignity and self-worth and diminished their right to feel safe, secure, and live in a clean homelike environment.</p> <p>Findings included:</p> <p>Review of Resident #20's face sheet, dated 09/20/2023, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, unspecified severe with agitation dementia, and unspecified anxiety disorder, recurrent moderate major depressive disorder, early onset Alzheimer's disease, unspecified altered mental status, and age-related physical debility.</p> <p>Review of Resident #20's annual MDS assessment, dated 07/03/2023, reflected she did not have a BIMS conducted because she was rarely/never understood and she had a short- and long-term memory problem. Resident #20 also required extensive assistance of two or more staff to dress.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #20's quarterly care plan, dated 08/28/2023, reflected she had a communication problem related to dementia, schizoaffective, bipolar disorder and unclear speech, had a potential psychosocial wellbeing problem related to schizoaffective disorder, dementia, bipolar and social isolation, had delirium as evidenced by disorganized thoughts and inattention related to dementia, and had impaired cognition function/impaired thought processes related to dementia and schizoaffective, bipolar disorder. Resident #20 also had an ADL self-care performance deficit related to dementia, impaired balance, debility, extrapyramidal and movement disorder and required limited to extensive assistance of one staff to dress.</p> <p>Review of Resident #20's progress notes reflected no notes regarding Resident #20 sitting in her room on her walker with her pants down and exposing her private parts.</p> <p>During an observation and interview on 09/18/2023 at 09:48 AM, Resident #20 was in her room sitting on her walker with her pants down and exposing her private parts. The surveyor informed CNA G. CNA G went into Resident #20's room and helped Resident #20 pull up her pants. Resident #20's call light was on the ground and away from her bed. Resident #20 was unable to answer the surveyor's questions.</p> <p>During an interview on 09/20/2023 at 12:42 PM, CNA H stated staff were required to help Resident #20 with pulling up and down her pants. CNA H stated she never seen Resident #20 sitting on her walker with her pants down and exposing her private parts. CNA H stated she did not know if residents could be negatively affected by residents exposing their private parts.</p> <p>During an interview on 09/20/2023 at 12:50 PM, CNA I stated she never seen Resident #20 sitting on her walker with her pants down and exposing her private parts. CNA I stated residents could not be negatively affected by residents exposing their private parts.</p> <p>During an interview on 09/20/2023 at 04:18 PM, CNA L stated she never seen Resident #20 sitting on her walker with her pants down and exposing her private parts. CNA L stated CNAs, LVNs, and CMAs were responsible for assisting residents with their ADLs. CNA L stated residents could be negatively affected by residents exposing their private parts.</p> <p>Review of Resident #395's face sheet, dated 09/20/2023, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including unspecified extradural and subdural abscess (circumscribed collections of suppurative material occurring in the spinal or intracranial epidural space and subdural space between the dura mater and arachnoid), unspecified cirrhosis of liver, chronic diastolic (congestive) heart failure, pain in left knee, muscle wasting and atrophy in right upper arm, left upper arm and other multiple sites, other abnormalities of gait and mobility, and need for assistance with personal care.</p> <p>Review of Resident #395's annual MDS assessment, dated 09/19/2023, reflected a BIMS of 9, indicating moderate cognitive impairment. The assessment did not indicate Resident #395's required ADL assistance.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #395's comprehensive care plan, initiated on 09/12/2023, reflected he had impaired cognitive function/dementia or impaired thought processes and acute pain related to his left knee pain. Resident #395 also had an ADL self-care performance deficit related to his cirrhosis of the liver, diabetes, and subdural and extradural abscess and required extensive assistance of one staff for toileting.</p> <p>Review of Resident #395's progress notes reflected he was on a urinal toileting program/assistive device.</p> <p>During an interview on 09/20/2023 at 12:05 PM, HK Q stated residents' rooms were cleaned more than once a day. HK Q stated the housekeeping supervisor documented when residents' rooms were cleaned. HK Q stated the housekeeping supervisor informed her and she would observe when residents' rooms needed to be cleaned. HK Q stated staff and residents have complained about housekeeping staff not cleaning residents' rooms. HK Q stated she never observed full urinals in residents' rooms. HK Q stated CNAs emptied residents' urinals. HK Q stated she was trained and in-serviced on abuse, neglect, physical environment, dignity, and housekeeping. HK Q stated in-services were given every week or every other week. HK Q stated residents could become sick and infected with a disease by the smell of urine in their rooms.</p> <p>During an observation and interview on 09/18/2023 at 02:48 PM, Resident #395 was laying in bed and watching tv. A plastic urinal was on the ground next to Resident #395's bed. The urinal was full. Resident #395's room smelled of urine. Resident #395 stated he had been trying to get staff to empty his urinal. Resident #395 stated his urinal had been on the ground for three hours. Resident #395 stated the urine odor from the urinal bothered him. Resident #395 stated he asked staff for a new urinal and never received it. Resident #395 stated staff cleaned his room, but they did not use the correct chemical to get rid of the urine odor.</p> <p>During an interview on 09/18/2023 at 03:01 PM, CNA E stated CNA L and CNA K worked on the hallway Resident #395 resided on. CNA E stated he had not been in Resident #395's room. CNA E stated residents' urinals were emptied and cleaned every two hours. CNA E stated CNAs were responsible for emptying and cleaning residents' urinals. CNA E stated he never received any complaints from residents about staff not emptying and cleaning their urinals. CNA E stated residents would feel neglected by staff not emptying and cleaning their urinals.</p> <p>During an interview on 09/20/2023 at 03:52 PM, MA O stated she was trained, in-serviced, and tested on abuse, neglect, physical environment, and dignity. MA O stated housekeeping cleaned residents' rooms once a day or more. MA O stated CNAs changed residents every two hours. MA O stated CNAs, CMAs, and LVNs emptied residents' urinals. MA O stated residents could be negatively affected by the smell of urine in their rooms.</p> <p>During an observation on 09/20/2023 at 03:59 PM, Resident #395's was laying in bed and watching tv. A plastic urinal was on the ground next to Resident #395's bed. The urinal was half full. Resident #395's room smelled of urine. Resident #395 stated his urinal was last emptied during lunch time.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/20/2023 at 04:10 PM, CNA L stated she was trained and in-serviced on neglect and dignity. CNA L stated she never seen residents have full urinals next to their beds. CNA L stated she informed residents to press their call light after using their urinals so she can empty and clean the urinals. CNA L stated CNAs emptied and cleaned residents' urinals every time residents pressed their call lights and whenever they observed residents had full urinals. CNA L stated she checked on residents every hour or more as needed. CNA L stated CNAs and LVNs could empty and clean residents' urinals. CNA L stated residents could face infection control issues by sitting in their rooms with full urinals.</p> <p>Review of Resident #65's Psychological Service Clinical note dated 03/20/23 reflected a diagnosis of schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), generalized anxiety and intermittent explosive disorder (an impulse-control disorder characterized by sudden episodes of unwarranted anger).</p> <p>Review of Resident #65's admitted MDS assessment dated [DATE] revealed a BIMS score of 15 indicating resident is cognitively intact and PASRR positive for serious mental illness.</p> <p>Review of Resident #65's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indication moderately impaired cognition and other behavioral symptoms not directed towards others eg. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste or verbal vocal symptoms like screaming or disruptive sounds.</p> <p>Review of Resident #65's Care Plan date initiated 07/14/21 and revised on 03/13/23 revealed Resident #65 has behavior problems of putting self on the floor in an inappropriate locations ie. in front of doors, the elevator, urinating throughout the building and on the back patio. Resident #65 has anger issues. Intervention dated 07/14/21 to provide a program of activities that is of interest and accommodates resident status. Care Plan date initiated 07/14/21 and revised on 03/13/23, indicated Resident #65 had behavior problem tossing crash cart or other items over, intervention dated 07/14/21 administer medications as ordered and anticipate and meet the resident's needs, caregivers to provide opportunity for positive interaction, attention, stop and talk with resident when passing by him. Interventions dated 07/05/22 referral to Psychiatry, interventions dated 07/14/21 explain all procedures to the resident before starting and allow the resident 15 minutes or PRN to adjust to changes, if reasonable discuss the residence behavior explain/reinforce why behavior is inappropriate and or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner and divert attention remove resident from the situation and take to alternate location as needed, monitor behavior episodes, and attempt to determine underlying cause, consider location time of day and person involved in situations. Document behavior and potential causes and praise any indication of the residence's progress/improvement in behavior.</p> <p>Observations on 09/19/23 at 10:00 am, 09/20/23 at 8:35 am, 9/20/23 at 2:20 pm, and 9/20 at 4:35 pm of Resident #65. During all observations he was seated in the second-floor dining area facing the nurse's station. He seemed calm, his clothes were dry, and no urine was noted in or by his seated area.</p> <p>Interview on 09/19/23 with Resident #65 at 8:35 a.m., revealed he did not feel safe at the facility all the time and some nurses (no names given) gave him a mean look.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 09/18/2023 with Resident #14 at 10:05 a.m., revealed Resident #65 could be violent, and he felt the staff were afraid to contain him. He revealed that Resident #65 has yelled at people, thrown caution signs, ripped the TV off the wall, and played his music very loudly when other residents are eating in the dining room. Resident #14 revealed he found the behaviors of Resident #65 disruptive.</p> <p>Interview on 09/19/23 with Environmental Supervisor at 8:47 am revealed Resident #65 has had urination issues since he was admitted to the facility. She revealed he does not wear an adult brief, would urinate while wearing his clothing until they became saturated, and the urine would leak onto the floor of area below him where his wheelchair was sitting. She revealed if Resident #65 had a bad day he would position himself in the middle of the elevator and ride up and down the elevator all day drinking cans of sodas that he took with him on the elevator. She revealed that the housekeeping staff would enter the elevator and mop up the wet areas around him. He would drink the cans of soda and when the can was empty, place it on the handrail of the elevator, and consume another soda, and urinate. She revealed that Resident #65 would sit in the dining room and urinate. She said it did not happen every week and he would go without urinating in the public areas of the facility for 2 or 3 days. She revealed they tried to clean around him. She said they always reported it to the charge nurse. She revealed that Resident #15 had complained about Resident #65 urinating on the dining room floor and the elevator. Residents have said (she does not remember their names) that when they were eating their meals, they didn't want to smell urine. Residents complained they couldn't go up and down the elevator when Resident #65 was sitting in the center of the elevator peeing. She said that residents were unhappy if they saw the urine and she would tell them someone spilled coffee and would quickly clean it up. She revealed that the last time Resident #65 urinated in a public area was in the dining room three weeks ago. She revealed that all the staff, including the Administrator and the DON knew about the issue with Resident #65 urinating in different common areas. The issue was discussed in the morning meetings. When asked if she thinks that the situation with Resident #65 is a problem and unsanitary, she revealed that it was not sanitary and sometimes housekeeping did not know that there was urine that needed to be cleaned because housekeeping was working in another area.</p> <p>Interview on 09/19/23 with Resident #12 at 11:13 am who said that on 09/16/23 the back elevator in the facility was out of order and there was only one operating elevator for all residents, staff, and food service. Resident #12 said Resident #65 was in the elevator and when he got off, there was urine on the floor of the elevator. When asked how she knew Resident #65 had urinated in the elevator, she said she saw him get on the elevator, and he left his soda cans on the handrail. She revealed that because this was the only elevator working at that time, the food service trays for the residents on the second floor were placed on that elevator to go to the second floor. She revealed that sometimes he stationed himself in the elevator and when she asked him to get out, he asked her, who the F*** do you think you are. She responded to him by telling him, Do you think you own the elevator? Resident #12 revealed that it happened daily. She said that he goes outside to urinate and urinates everywhere in the facility. She said she does not want to smell his urine. She said there were pictures of the residents hung in the hallways and he pulled all the pictures down and broke them. She said he pulled the TV off the wall and broke it. She revealed that she found Resident #65's behavior upsetting and disgusting.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 09/20/23 with the DON at 4:34 pm who revealed that when Resident #65 did not, get his way he became aggressive. He became upset if he did not get his sodas. He tore the photos of the residents down from the wall on the second floor and tore the TV off the wall. She revealed he urinated in the elevator, the nurses' station on the first floor, when fully clothed in his room. She revealed this could be a sanitation issue. She revealed that the residents sometimes notified the staff that he urinated, and it is not the resident's responsibility to notify the staff when there was urine on the floor. She revealed that if a staff member or a resident finds urine on the floor, they did not know how long the urine had been there and residents might have travelled through the urine using their wheelchairs or walked through it spreading it through the facility. About a month ago she saw Resident #65 at the nurses' station on the first floor in his wheelchair with urine beneath his chair.</p> <p>Interview on 09/20/23 with the first floor SW A at 4:08 pm who revealed he knew Resident #65 drank a lot of fluids and urinated in the facility and he knew that Resident #65 threw items (he did not specify what items) but he did not believe that Resident #65 intentionally threw things at other residents.</p> <p>Interview on 09/20/23 with the MDS Coordinator at 12:04 pm who revealed that Resident #65 has had some inappropriate behaviors that he has been care planned for. She said he has yelled and cursed at other residents and thrown pieces of furniture and a coke. She said he broke a TV and has had issue urinating while in the resident common areas and in the elevator. She revealed he stayed on elevator and rode it up and down, and urinated. When asked how the behaviors might affect the residents, she revealed that some of the female residents would be scared, Resident #65's behaviors would be disruptive, and residents would be disturbed because of the noise factor of the verbal behaviors and the smell of the urine. She revealed, who wants to ride in an elevator full of urine?</p> <p>Interview with 09/20/23 with the Administrator at 6:39 pm reflected he was aware of Resident #65's urination issues and said Resident #65 had not done it in a while. When he was told that the DON she observed, about a month ago, Resident #65 at the nurses' station on the first floor in his wheelchair with urine beneath his chair and a resident who said that Resident #65 urinated in the elevator the weekend of 09/19/23 and would not get off the elevator he said he was not aware of these incidents. The Administrator revealed that about a year ago the facility had to replace the flooring in the elevator because of it was saturated with urine. The Administrator agreed that Resident #65 has had outbursts. The Administrator revealed that Resident #65 broke a TV, picture frames, and turned over tables, but Resident #65 did not hit anyone, and he is not aware that he has thrown anything in an effort to harm anyone else. He said that if Resident #65 had injured someone, the facility would have discharged him. The Administrator said that the urine is a problem, but the housekeeping staff is quick to clean up the urine when Resident #65 has urinated and feels it does not stay there for very long. When asked about the urine spreading in the facility when Resident #65 rolls his wheelchair through the urine he said he feels the housekeeping staff had does a good job cleaning it up and they have cleaned Resident #65's wheelchair.</p> <p>Review of Clinical Treatment Plan Review (Plan of Care) dated 06/30/23 reflected the patient's behavior does not improve in response to participation in therapy, the patient's emotion does not improve in a response to participation in therapy, treatment does prevent a decline that would otherwise be expected.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. "Nursing personnel are not assigned to routine housekeeping duties. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Each occupied resident room is cleaned and put in order daily and as needed. Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices. Odor control is achieved by prompt cleansing of bedpans, urinals, and commodes by prompt and proper care of residents and soiled linens, by good housekeeping procedures, and by approved ventilation.</p>		

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  09/20/2023
NAME OF PROVIDER OR SUPPLIER  Heritage Park Rehabilitation and Skilled Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE  2806 Real St Austin, TX 78722	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45830</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside the facility for one (Resident #103) of seven reviewed, in that:</p> <p>The facility failed to provide a communication aide (examples being paper and writing implement or white board) for Resident #103 after a diagnosis of hearing loss.</p> <p>This failure placed residents at risk of a lack of a dignified existence, self-determination, and quality of life.</p> <p>Findings included:</p> <p>Review of Resident #103's undated face sheet reflected a [AGE] year-old woman facility admitted date 01/04/22 with diagnoses including cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), unspecified, unspecified hearing loss, left ear, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of Audiological Evaluation dated 04/18/23 revealed screening indicated profound hearing loss and recommended follow up with Ear Nose and Throat doctor due to degree of loss. Possible cochlear implant (is a small, complex electronic device that can help to provide a sense of sound to a person who is profoundly deaf) candidate.</p> <p>Review R#103's annual MDS assessment dated [DATE] revealed she has highly impaired hearing - the absence of useful hearing and has a BIMS score of 14 reflecting resident is cognitively intact.</p> <p>Resident #103's quarterly care plan revealed resident is identified as having PASRR positive status related to a severe mental illness of schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior) and PTSD (post-traumatic stress disorder is a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event). Resident has a communication problem related to hearing deficit, deaf in one or both ears and is at risk for decline dated 12/20/2022 and revision on 03/10/2023. Resident is independent from staff for meeting intellectual, and social needs however needs help both emotionally and physically related to cognitive deficits date Initiated 12/12/2022 and revision on: 12/12/2022. Resident #103 has a behavior problem (omitting details concerning incidents, exaggerating or minimizing severity of events/accusations, inconsistent storytelling) related to bipolar II disorder, cerebral infarction, and PTSD date Initiated: 12/20/2022 and revision on: 06/08/2023. Resident #103 had impaired cognitive function or impaired thought processes related to impaired decision making, psychotropic drug use, short term memory loss related to cerebral infarction, anxiety, depression date Initiated 03/10/2023 and revision on 03/10/2023.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 09/18/23 of R#103 at 10:03 am, when surveyor entered R#103's room and surveyor was unable to communicate with resident verbally to conduct interview. Surveyor did not observe a white board, writing implements, or communication device. Surveyor had a pencil and notepad with her so conducted interview with resident using surveyor paper and pencil.</p> <p>Interview on 09/18/23 with R#103 at 10:03 am, revealed she lost her hearing in the last 5 months and nd has communicated with the staff by writing everything down. She said when she does not have any paper or a pencil, she is unable to communicate. Resident #103 revealed that this made it difficult to communicate with the staff about her needs.</p> <p>Interview on 09/20/23 with the DON at 4:34 pm, who revealed, when she was told that when surveyor attempted to interview R#103 there were no communication devices that it would bother her a lot if she could not make people understand her. The DON said it is the responsibility of the DON and the ADMINISTRATOR for R#103 to have the ability to communicate.</p> <p>Interview on 09/20/23 with the ADMINISTRATOR at 6:40 pm who revealed, when he was told that when surveyor attempted to interview R#103 there were no communication devices available to the resident that he knows that R#103 had a hearing issue but he feels that it is more of a psychological issue that he is not worried about R#103 making her needs known and getting her needs meet. Surveyor asked even if R#103's hearing issues might be more psychologically based then medically based should her needs still be meet and he replied that even if her hearing is more psychological, that need should be addressed and she should be provided the ability to communicate.</p> <p>Interview on 09/20/23 with the ADMINISTRATOR who said they have no facility policy regarding meeting resident communication needs.</p> <p>Review of the facility's Promoting/Maintaining Resident Dignity policy and procedure, implemented on 01/13/2023, reflected the following:</p> <p>Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.</p> <p>Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</li> <li>2. During interactions with residents, staff must report, document and act upon information regarding resident preferences.</li> <li>3. Interview results will be documented; the provision of care and care plans will be revised, if appropriate, based on information obtained from resident interviews.</li> <li>4. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.</li> </ol> <p>(continued on next page)</p>		

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

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Respond to requests for assistance in a timely manner.</p> <p>9. Groom and dress residents according to resident preference.</p> <p>11. Respect the resident's living space and personal possessions.</p> <p>12. Maintain resident privacy.</p> <p>14. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.</p> <p>15. Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy.</p> <p>Review of the facility's Exercising Your Rights as a Nursing Facility Resident, undated, reflected the following:</p> <p>Your Right to Accommodations: Your facility must provide full and equal access for people with disabilities. You have a right to request a reasonable accommodation, which is a change in policy or practice, communication, or the physical space needed for a person with a disability to have equal opportunity to use their home.</p> <p>Your Right to Safety and Quality Care: Freedom From Abuse, Neglect, and Exploitation: You have the right to be free of abuse, neglect, and exploitation. People inside or outside of the facility must not harm you physically or mentally or misuse your property or money. Your facility must:</p> <ul style="list-style-type: none"> <li>o Protect you from abuse, neglect, and exploitation.</li> <li>o Train all staff on how to prevent, identify, stop, and report abuse, neglect, and exploitation.</li> </ul> <p>Safe Surroundings: You have the right to a safe, clean, and comfortable home environment. The facility must:</p> <ul style="list-style-type: none"> <li>o Have enough housekeeping and maintenance staff to keep the building clean and safe.</li> <li>o Clean your room daily.</li> </ul> <p>Quality Care: You have the right to receive all the care necessary for you to have the highest possible level of health. This includes medical care, mental health care, rehabilitative therapies, and supplies. The facility must have enough</p> <p>staff to provide you with care and respond to your needs. Facility staff must be qualified and trained to care for you.</p> <p>Your Right to Be Treated with Dignity and Respect: You have the right to be treated with dignity and respect. You have the right to courtesy and fair treatment from facility staff. Being treated with dignity and respect also means you have the right to make decisions about your life and care. Your facility must respect your choices and preferences.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47065</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure each resident had a right to a safe, clean, comfortable and homelike environment for 4 (Resident #41, #129, #141, and #395) of 169 residents reviewed for environment.</p> <ol style="list-style-type: none"> <li>1. Resident #41, #129, #141, and #395's rooms had a urine odor.</li> <li>2. The facility's memory care unit had a urine odor and sticky floors.</li> </ol> <p>These deficient practices placed residents at risk of discomfort and diminished quality of life.</p> <p>Findings included:</p> <p>Review of Resident #41's face sheet, dated 09/20/2023, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including late onset Alzheimer's disease, vascular age-related physical debility, dementia, paranoid schizophrenia, unspecified recurrent major depressive disorder, unspecified anxiety disorder, and muscle wasting and atrophy.</p> <p>Review of Resident #41's annual MDS assessment, dated 09/20/2023, reflected she did not have a BIMS conducted because she was rarely/never understood.</p> <p>Review of Resident #41's quarterly care plan, dated 08/31/2023, reflected she had an urge bladder incontinence and an ADL self-care performance deficit related to Alzheimer's, dementia, osteoarthritis, and impaired balance.</p> <p>Review of Resident #129's face sheet, dated 09/20/2023, reflected [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including bipolar type schizoaffective disorder, unspecified dementia, unspecified cirrhosis of liver, legal blindness, unspecified intracranial injury without loss of consciousness, and muscle wasting and atrophy in right upper arm and left upper arm.</p> <p>Review of Resident #129's annual MDS assessment, dated 09/18/2023, reflected a BIMS of 5, indicating severe cognitive impairment.</p> <p>Review of Resident #129's quarterly care plan, dated 08/28/2023, reflected he had a communication problem related to neurological symptoms from his traumatic brain injury diagnosis, had impaired cognitive function/dementia or impaired thought processes related to dementia and traumatic brain injury, had limited physical mobility related to dementia, balance/gait unsteadiness due to being legally blind, was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficit diagnoses of dementia and schizophrenia, and had an ADL self-care performance deficit related to confusion, dementia, impaired balance due to traumatic brain injury and being legally blind.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #141's face sheet, dated 09/20/2023, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including delusional disorders, unspecified dementia, unspecified anxiety disorder, muscle wasting and atrophy, and other abnormalities of gait and mobility.</p> <p>Review of Resident #141's quarterly MDS assessment, dated 09/11/2023, reflected a BIMS of 5, indicating severe cognitive impairment.</p> <p>Review of Resident #141's comprehensive care plan, dated 09/08/2023, reflected she had impaired cognitive function/dementia or impaired thought processes related to dementia and delusional disorder, had limited physical mobility related to weakness, was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits due to dementia, had a communication problem related to dementia, and had an ADL self-care performance deficit related to dementia and delusional disorder.</p> <p>Review of Resident #395's face sheet, dated 09/20/2023, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including unspecified extradural and subdural abscess, unspecified cirrhosis of liver, chronic diastolic (congestive) heart failure, pain in left knee, muscle wasting and atrophy in right upper arm, left upper arm and other multiple sites, other abnormalities of gait and mobility, and need for assistance with personal care.</p> <p>Review of Resident #395's annual MDS assessment, dated 09/19/2023, reflected a BIMS of 9, indicating moderate cognitive impairment.</p> <p>Review of Resident #395's comprehensive care plan, initiated on 09/12/2023, reflected he had impaired cognitive function/dementia or impaired thought processes and acute pain related to his left knee pain. Resident #395 also had an ADL self-care performance deficit related to his cirrhosis of the liver, diabetes, and subdural and extradural abscess and required extensive assistance of one staff for toileting.</p> <p>Review of Resident #395's progress notes reflected he was on a urinal toileting program/assistive device.</p> <p>During an observation on 09/18/2023 at 09:48 AM, Resident #41 was not in her room. Resident #41's room smelled of urine. Resident #41's call light was behind her bed. Resident #41 was sitting in the memory care unit's dining area. Resident #41 was unable to answer the surveyor's questions.</p> <p>During an observation and interview on 09/18/2023 at 10:00 AM, Resident #129 was sleeping in his bed. Resident #129 had a bed sheet covering his body and face. Resident #129's room smelled of urine.</p> <p>During an observation and interview on 09/18/2023 at 02:48 PM, Resident #395 was laying in bed and watching tv. A plastic urinal was on the ground next to Resident #395's bed. The urinal was full. Resident #395's room smelled of urine. Resident #395 stated he had been trying to get staff to empty his urinal. Resident #395 stated his urinal had been on the ground for three hours. Resident #395 stated the urine odor from the urinal bothered him. Resident #395 stated he asked staff for a new urinal and never received it. Resident #395 stated staff cleaned his room, but they did not use the correct chemical to get rid of the urine odor.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/18/2023 at 11:01 AM, CNA I stated residents' rooms were cleaned every 20 minutes. CNA I stated housekeeping staff were responsible for cleaning residents' rooms every morning, lunch, and evening time. CNA I stated residents could not be negatively affected by the smell of urine in their rooms and the memory care unit hallway.</p> <p>During an interview on 09/18/2023 at 03:01 PM, CNA E stated CNA L and CNA K worked on the hallway Resident #395 resided on. CNA E stated he had not been in Resident #395's room. CNA E stated residents' urinals were emptied and cleaned every two hours. CNA E stated CNAs were responsible for emptying and cleaning residents' urinals. CNA E stated he never received any complaints from residents about staff not emptying and cleaning their urinals. CNA E stated residents would feel neglected by staff not emptying and cleaning their urinals.</p> <p>During an interview on 09/20/2023 at 12:05 PM, HK Q stated residents' rooms were cleaned more than once a day. HK Q stated the housekeeping supervisor documented when residents' rooms were cleaned. HK Q stated the housekeeping supervisor informed her and she would observe when residents' rooms needed to be cleaned. HK Q stated staff and residents have complained about housekeeping staff not cleaning residents' rooms. HK Q stated CNAs emptied residents' urinals. HK Q stated she was trained and in-serviced on abuse, neglect, physical environment, dignity, and housekeeping. HK Q stated in-services were given every week or every other week. HK Q stated residents could become sick and infected with a disease by the smell of urine in their rooms and the memory care unit hallway.</p> <p>During an observation on 09/20/2023 at 12:18 PM, the memory care unit hallway smelled of urine and the floor was sticky.</p> <p>During an observation and interview on 09/20/2023 at 12:24 PM, Resident #129 was laying in bed. Resident #129 was unable to answer the surveyor's questions.</p> <p>During an observation and interview on 09/20/2023 at 12:26 PM, Resident #141's room smelled of urine. Resident #141 stated staff cleaned her room on the morning of 09/20/2023. Resident #141 stated she asked staff in the past to clean her room and they did not do it. Resident #141 stated staff did not clean her room at all. Resident #141 stated she was bothered by staff not cleaning her room. Resident #141 stated her room never smelled of urine.</p> <p>During an interview on 09/20/2023 at 12:33 PM, CNA H stated she was trained on physical environment, neglect, and dignity. CNA H stated staff focused more on residents' care than residents' room. CNA H stated housekeeping staff cleaned residents' rooms twice a day or more if needed. CNA H stated CNAs cleaned residents' spills. CNA H stated she noticed a strong urine odor in residents' rooms and the memory care unit. CNA H stated the strong urine odor came from most residents who were incontinent. CNA H stated cleaning did not help get rid of the urine odor in the memory care unit. CNA H stated staff could not use chemicals to get rid of the urine odor because the chemicals could harm the residents. CNA H stated residents could not be negatively affected by the smell of urine in their rooms and the memory care unit hallway.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/20/2023 at 12:47 PM, CNA I stated residents' rooms and the memory care unit hallway smelled of urine. CNA I stated housekeeping staff last cleaned residents' rooms and the memory care unit hallway in the morning of 09/20/2023. CNA I stated housekeeping staff cleaned residents' rooms and the memory care unit hallway three times a day or more as needed. CNA I stated residents could not be negatively affected by the smell of urine in their rooms and the memory care unit hallway. CNA I stated she was trained and in-serviced on abuse, neglect, physical environment, and dignity. CNA I stated in-services were often given to staff.</p> <p>During an interview on 09/20/2023 at 03:52 PM, MA O stated she was trained, in-serviced, and tested on abuse, neglect, physical environment, and dignity. MA O stated housekeeping cleaned residents' rooms once a day or more. MA O stated CNAs changed residents every two hours. MA O stated CNAs, CMAs, and LVNs emptied residents' urinals. MA O stated residents could be negatively affected by the smell of urine in their rooms.</p> <p>During an observation on 09/20/2023 at 03:59 PM, Resident #395's was laying in bed and watching tv. A plastic urinal was on the ground next to Resident #395's bed. The urinal was half full. Resident #395's room smelled of urine. Resident #395 stated his urinal was last emptied during lunch time.</p> <p>During an interview on 09/20/2023 at 04:10 PM, CNA L stated she was trained and in-serviced on neglect, dignity and physical environment. CNA L stated she never seen residents have full urinals next to their beds. CNA L stated she informed residents to press their call light after using their urinals so she can empty and clean the urinals. CNA L stated CNAs emptied and cleaned residents' urinals every time residents pressed their call lights and whenever they observed residents had full urinals. CNA L stated she checked on residents every hour or more as needed. CNA L stated CNAs and LVNs could empty and clean residents' urinals. CNA L stated residents could face infection control issues by sitting in their rooms with full urinals.</p> <p>During an interview on 09/20/2023 at 6:50 PM, ADMINISTRATOR stated there was no policy and procedure on homelike environment and draining and cleaning urinals.</p> <p>Review of the facility's General Housekeeping Policies, undated, reflected the following:</p> <p>The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. "Nursing personnel are not assigned to routine housekeeping duties. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Each occupied resident room is cleaned and put in order daily and as needed. Floors are maintained in good condition and cleaned regularly. Floor polishes provide a non-slip finish and rugs are not used except for non-slip entrance mats. Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices. Odor control is achieved by prompt cleansing of bedpans, urinals, and commodes by prompt and proper care of residents and soiled linens, by good housekeeping procedures, and by approved ventilation.</p> <p>Review of the facility's Exercising Your Rights as a Nursing Facility Resident, undated, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Your Right to Safety and Quality Care: Freedom From Abuse, Neglect, and Exploitation: You have the right to be free of abuse, neglect, and exploitation. People inside or outside of the facility must not harm you physically or mentally or misuse your property or money. Your facility must:</p> <ul style="list-style-type: none"> <li>o Protect you from abuse, neglect, and exploitation.</li> <li>o Train all staff on how to prevent, identify, stop, and report abuse, neglect, and exploitation.</li> </ul> <p>Safe Surroundings: You have the right to a safe, clean, and comfortable home environment. The facility must:</p> <ul style="list-style-type: none"> <li>o Have enough housekeeping and maintenance staff to keep the building clean and safe.</li> <li>o Clean your room daily.</li> </ul> <p>Quality Care: You have the right to receive all the care necessary for you to have the highest possible level of health. This includes medical care, mental health care, rehabilitative therapies, and supplies. The facility must have enough staff to provide you with care and respond to your needs. Facility staff must be qualified and trained to care for you.</p> <p>Your Right To Be Treated With Dignity and Respect: You have the right to be treated with dignity and respect. You have the right to courtesy and fair treatment from facility staff. Being treated with dignity and respect also means you have the right to make decisions about your life and care. Your facility must respect your choices and preferences.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46708</p> <p>Based on observation, interview, and record review, the facility failed to protect one (Residents #78) of one of one reviewed, from verbal abuse, in that:</p> <p>The facility failed to ensure Resident #78 was not verbally abused by Resident #90.</p> <p>This failure could most likely place residents at risk of fear, depression, intimidation, and a diminished quality of life due to verbal abuse.</p> <p>Findings included:</p> <p>Review of face sheet for Resident #78 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified dementia, mild, with mood disturbance, schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior), depressive type, major depressive disorder, recurrent extrapyramidal (movement dysfunction such as continuous spasms and muscle contractions) and movement disorder and need for assistance with personal care.</p> <p>Review of quarterly minimum data set (MDS) for Resident #78 conducted on 09/06/23 reflected a brief interview for mental status (BIMS) score of 12, suggesting moderate cognitive impairment.</p> <p>Review of care plan reflected that Resident #78 is PASRR positive related to a severe mental illness: depression, schizoaffective disorder, and required specialized services to maintain his highest level of practicable wellbeing. He presented with impaired cognition and cognition fluctuates from day to day. He needed cues and supervision for ADLS related to his diagnoses of dementia and schizophrenia. He is at risk for decline - date initiated 04/24/18 and revision on 03/02/20. Resident #78 presents with indicators of delirium at times, inattention, and disorganized thinking at times and is at risk for decline - date initiated - 07/18/2018 and revision on 03/02/2020. He presented with a history of depression and attempting suicide by overdosing on depression medication by resident's medical history. He is at risk for decline at risk for needs not being met - date Initiated: 04/24/2018 and revision on: 02/24/2021.</p> <p>Observation during supervised scheduled resident smoke time on 09/19/23 at 9:33 am, R#90 told R#78 to, shut up. Resident #90 was yelling out loud to no one in particular, but clearly his yelling was directed to Resident #78 because Resident #78 was the resident requesting cigarettes. R#90 said, he (meaning R#78) will sit there and ask for cigarettes again and again, F***** A, just tell him No, he doesn't know what he has or what he doesn't have. R#90's tone was condescending and demeaning. Two staff members, RA and ENVIRONMENTAL SUPERVISOR were present when Resident #90 said this. No intervention was made by either staff member until after Resident #90 made the statements.</p> <p>Observation during supervised scheduled resident smoke time on 09/19/23 at 9:33 of R#78. Resident #78 did not acknowledge</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Heritage Park Rehabilitation and Skilled Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE  2806 Real St Austin, TX 78722	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #90 speaking about him. He was attempted to obtain a cigarette. He did not appear as if he had the ability to communicate because he used hand gestures, reaching, and pointing, towards the cigarettes in the containers, and not making a verbal request. He did not speak with other residents or make eye contact with others and his affect was flat.</p> <p>Interview on 09/20/23 with Resident #78 at 5:30 pm who revealed people were nice to him, but some people in the smoking area are mean to him.</p> <p>Interview on 09/20/23 at 2:30 pm with RA who was outside when Resident #90 made the statements about Resident #78 witnessed by the surveyor. He said he usually is not assigned to the smoking area, but he was the residents were respectful and not mean to Resident #78. When asked if he thought what R#90 said to R#78 was abusive he said he did not hear or recall R#90 saying anything.</p> <p>Interview on 09/20/23 at 3:05 pm with ENVIRONMENTAL SUPERVISOR who was outside when Resident #90 made the statements about Resident #78 witnessed by the surveyor. She said she usually is not assigned to the smoking area and activities takes care of smoking, but, because there was no one else, she handed out the cigarettes. She said she was busy handing out cigarettes and it took her a minute to realize what Resident #90 was saying before she told him to be nice to Resident #78. She said because she was not in the smoking area a lot, she does not know if they are not nice to Resident #78.</p> <p>Interview on 09/20/23 with the Activity Aide/Smoke Aide at 12:42 pm revealed she some residents talked to Resident #78 in a disrespectful manner and said things like, G** D*** Resident #78 you have already been out here stop coming out here. The Activity Aide/Smoke Aide said she tried to redirect the residents, but some residents were mean to him. She said that is not okay because Resident #78 had feelings.</p> <p>Telephone interview on 09/20/23 at 4:50 with Resident #78's Guardian at Family Elder Care Advocate who revealed that when she visited him, he said that a resident was bullying him during smoke times, and she sent an email to one of the facility social workers.</p> <p>Interview on 09/20/23 at 4:19 with SW B. revealed she knows Resident #78 pretty good. When surveyor told her she was surprised that his BIMS score was as high as a 12 based on observing Resident #78 SW 2nd fl. replied that R#78, knows what he knows, and he was able to tell her what happened with situations. She said Resident #78 has never told her that the residents in the smoking area were mean to him. She said Resident #78 had a non-emotional type attitude and he did not show that his feelings were hurt. She revealed she had never asked him if his feelings got hurt or how he felt. When the surveyor told her what Resident #90 said to him she said that those were harmful things to say and no one on the staff had brought it to her attention. She said she would consider what Resident #90 said to Resident #78 to be resident to resident verbal abuse. SW B. revealed that when she was outside the office with Resident #78 and he was waiting to come into to the office to have an interview with the surveyor, she stopped a resident from being mean to Resident #78.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/20/23 at 4:34 pm with the DON who revealed that she has seen R#78 move to the front of the smoking line to get to the door first. Residents told him, Resident 78, get out of the door, get out of the way and when she saw the, she redirected Resident #78 and the other residents. She revealed that she felt Resident #78 was unaware of these comments and he did respond to them. When surveyor told her what Resident #90 said to Resident #78 she did not know if that would make Resident #78 feel bad. When surveyor told her about the conversation between Resident #78 and his guardian, she said it was the first time that she heard this, and it made her feel bad for Resident #78.</p> <p>Interview on 09/20/23 at 6:39 pm with the ADMINISTRATOR who revealed, when he was told what Resident #90 said to Resident #78 in the smoking area, that he would not consider residents speaking to each other abuse. He said you can tell when someone is affected by a conversation by their demeanor and with Resident #78 it is hard to tell his thoughts or feelings by his demeanor. He said that if there are signs or symptoms of distress, that goes along with psychological abuse, and the staff do intervene to resolve those concerns. He revealed that he has heard other residents speak badly to R#78 when R#78 had soiled his pants, but they redirected the residents who said unkind things and moved quickly to get R#78 cleaned. ADMINISTRATOR further said that if Resident #78 were at Walmart and Resident #78 soiled his pants people might also say things to ridicule Resident #78. Surveyor suggested to the ADMINISTRATOR that Resident #78 is not at Walmart for a reason and asked if it is the facilities responsibility to protect Resident #78 when then happens and ADMINISTRATOR agreed that the facility is there to protect the resident.</p> <p>Interview on 09/20/23 with SW A. at 4:08 pm revealed that some residents in the smoking area are mean to him and tell him, Go back in Resident #78, go back inside R#78, it's not your turn.</p> <p>Record review of R#78's Guardian at Family Elder Care Advocate notes from 02/23/23 which reflected when she visited R#78 on 02/03/23 she reviewed with him his [NAME] of Rights. Her notes reflected they were downstairs on a bench by the nurse's station and when she had completed the review of the resident rights Resident #78 revealed That guy's been bothering me (pointing to someone at the nurses' station) can you make him stop? The notes from Resident #78's guardian revealed that the individual came over to Resident #78 and started yelling at him. Resident #78 told his guardian that he had called the police on the man twice. The man told Resident #78 to, Stop complaining about me! I'm going to put you in jail! The notes from the guardian reflected that she attempted to discourage the man from yelling until he walked away. The guardian told Resident #78 that she would speak to someone about this and assured him that the man can't put him in jail. He said, I hope not. The guardian's note revealed that she spoke with a staff member (name unknown) who said some people picked on Resident #78 outside in the smoking area because he is incontinent, and they don't like the odor. The guardian's note reflected the staff member described the residents like kids in grammar school and they tell the individuals to leave him alone and try to separate R#78.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of email dated 02/23/23 from Resident #78's guardian to SW A revealed that she told him she visited Resident #78 on 02/23/23 and they were downstairs by the elevator, and she reviewed Resident #78's [NAME] of Rights with him. In the email the guardian said that Resident #78 told her someone is threatening him, and can she do something about it? She said in the email that Resident #78 motioned to the man who was by the nurses' station and the man heard Resident #78 or saw him pointing and came over to him, yelling at R#78 not to threaten him and telling him he's putting Resident #78 in jail. The guardian's email to the SW 1st fl. revealed this had happened a few times when she was there. The guardian's email to the SW 1st fl. reflected that she did speak with a staff member about it and the staff member said the man was like a bully and picks on Residednt #78. The guardian's email reflected she just wanted to make sure the social worker was aware because Resident #78 specifically asked the guardian if she could take action. The guardian's notes revealed that she is not sure what she can do other than pass it on to the social worker and she did not know if the social worker could talk to Resident #78 so Resident #78 knew the guardian followed up.</p> <p>Record review of Resident #78's guardian notes dated 03/15/23 reflected Resident #78 said he was still being bothered but he couldn't tell her how, and he said it wasn't anyone yelling. He said it was other things but when his guardian tried to have him tell her what he meant, he didn't elaborate and did not appear distressed but rather like he didn't know what else to say.</p> <p>Review of the facility's Promoting/Maintaining Resident Dignity policy and procedure, implemented on 01/13/2023, reflected the following:</p> <p>Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.</p> <p>Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</li> <li>2. During interactions with residents, staff must report, document and act upon information regarding resident preferences.</li> <li>3. Interview results will be documented; the provision of care and care plans will be revised, if appropriate, based on information obtained from resident interviews.</li> <li>4. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.</li> <li>6. Respond to requests for assistance in a timely manner.</li> <li>9. Groom and dress residents according to resident preference.</li> <li>11. Respect the resident's living space and personal possessions.</li> <li>12. Maintain resident privacy.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>14. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.</p> <p>15. Random observations and/or verifications are conducted by the Director of Nursing Services (DNS), or designee, to ensure compliance with this policy.</p> <p>Review of the facility's Exercising Your Rights as a Nursing Facility Resident, undated, reflected the following:</p> <p>Your Right to Accommodations: Your facility must provide full and equal access for people with disabilities. You have a right to request a reasonable accommodation, which is a change in policy or practice, communication, or the physical space needed for a person with a disability to have equal opportunity to use their home.</p> <p>Your Right to Safety and Quality Care: Freedom From Abuse, Neglect, and Exploitation: You have the right to be free of abuse, neglect, and exploitation. People inside or outside of the facility must not harm you physically or mentally or misuse your property or money. Your facility must:</p> <ul style="list-style-type: none"> <li>o Protect you from abuse, neglect, and exploitation.</li> <li>o Train all staff on how to prevent, identify, stop, and report abuse, neglect, and exploitation.</li> </ul> <p>Safe Surroundings: You have the right to a safe, clean, and comfortable home environment. The facility must:</p> <ul style="list-style-type: none"> <li>o Have enough housekeeping and maintenance staff to keep the building clean and safe.</li> <li>o Clean your room daily.</li> </ul> <p>Quality Care: You have the right to receive all the care necessary for you to have the highest possible level of health. This includes medical care, mental health care, rehabilitative therapies, and supplies. The facility must have enough staff to provide you with care and respond to your needs. Facility staff must be qualified and trained to care for you.</p> <p>Your Right To Be Treated With Dignity and Respect: You have the right to be treated with dignity and respect. You have the right to courtesy and fair treatment from facility staff. Being treated with dignity and respect also means you have the right to make decisions about your life and care. Your facility must respect your choices and preferences.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45830</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two (Resident #102 and Resident #182) of eight residents reviewed for activities of daily living.</p> <p>The facility failed to ensure Resident #102 received nail care.</p> <p>The facility failed to ensure Resident #182 received shaving care.</p> <p>These failures placed residents at risk of diminished support with activities of daily living.</p> <p>Findings included:</p> <p>A record review of Resident #102's face sheet dated 9/20/2023 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of schizophrenia (mental disorder), unspecified dementia (cognitive decline), and major depressive disorder (depression).</p> <p>A record review of Resident #102's quarterly MDS assessment dated ,d+[DATE] reflected a BIMS score of 9, which indicated moderate cognitive impairment.</p> <p>A record review of Resident #102's care plan last revised on 9/09/2023 reflected she had impaired visual function and CNAs were to assist her with ADLs. Resident #102's care plan also reflected she had ADL self-care performance deficit and required supervision to limited assistance with personal hygiene. There was no documented history of Resident #102 refusing nail care.</p> <p>A record review of Resident #102's progress notes dated 8/21/2023-9/20/2023 reflected no documented refusals of nail care.</p> <p>A record review of Resident #182's face sheet dated 9/20/2023 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia (cognitive decline), major depressive disorder, excoriation (skin-picking) disorder, and need for assistance with personal care.</p> <p>A record review of Resident #182's quarterly MDS assessment reflected a BIMS score of 2, which indicated severely impaired cognition.</p> <p>A record review of Resident #182's care plan last revised on 8/03/2023 reflected she had ADL self-care performance deficit related to dementia and history of CVA. There was no documented history of Resident #182 refusing shaving care.</p> <p>A record review of Resident #182's progress notes dated 8/21/2023-9/20/2023 reflected no documented refusals of shaving care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 9/18/2023 at 9:12 a.m., Resident #102 was observed sitting on her bed. Resident #102's fingernails were observed to be very long and extended about half a centimeter from her fingertips. Resident #102 stated she liked to keep her nails short and that someone had offered to trim her nails a few days prior but they never came back. Resident #102 did not recall who this was but said her nails were last trimmed about three weeks prior. Resident #102 stated, I haven't been able to round up anyone.</p> <p>During an observation and interview on 9/19/2023 at 9:46 a.m., Resident #182 was observed in bed with long whiskers on her chin. Resident #182 stated she preferred it be shaved off and that staff had not offered to shave her. Resident #182 stated they don't do that during shower and said she could not remember when her last shower was.</p> <p>During an observation and interview on 9/20/2023 at 8:56 a.m., Resident #102 was observed with long fingernails and Resident #102 stated her nails were too long. Resident #102 stated she had asked someone to trim them but they did not trim her nails-she did not specify who or when this was.</p> <p>During an observation and interview on 9/20/2023 at 9:01 a.m., Resident #182 was still observed with whiskers on her chin and she said her last shower was two days ago (9/18/2023).</p> <p>During an observation interview on 9/20/2023 at 9:04 a.m., CNA C stated staff trimmed female residents' chin hair and nails on shower days and on Sundays. CNA C stated she worked the 6:00 a.m.-2:00 p.m. shift and Resident #182's showers were on the 2:00-10:00 p.m. shift so she was not sure when Resident #182's last shower was. CNA C stated she was familiar with Resident #182 and [Resident #182] doesn't refuse-all you have to do is talk to her and communicate with her. CNA C stated she was not sure whether anyone had offered to trim Resident #182's chin hair. Observed CNA C enter Resident #182's room. CNA C inspected Resident #182 and said yes that her chin hair needed to be shaved.</p> <p>During an observation and interview on 9/20/2023 at 9:14 a.m., CNA D stated staff offered a nail trim and shave during showers and on Sundays. CNA D stated Resident #102's shower days were Mondays, Wednesdays and Fridays but she did not know when her last was because she was off work on Monday 9/18/2023 and Resident #102 refused a shower that day (9/20/2023). CNA D observed Resident #102's nails and said they were long.</p> <p>During an interview on 9/20/2023 at 9:47 a.m., Resident #182 stated no that no one had offered her a shave and yes she would like to have her chin shaved.</p> <p>During an interview on 9/20/2023 at 9:53 a.m., CNA C stated she worked the 400 hall (where Resident #102 resided) on Sunday 9/17/2023 but no she did not offer Resident #102 a nail trim. CNA C stated she worked the left hand side of the hall and her partner NA M worked the right hand side of the hall where Resident #102 resided. CNA C stated NA M left early that day (Sunday 9/17/2023) after breakfast because she had a stomachache. CNA C stated yes that perhaps Resident #102 was not offered a nail trim due to NA M leaving early.</p> <p>During an interview on 9/20/2023 at 10:26 a.m., the ADON stated shaves were offered on shower days and on Sundays. The ADON stated if residents refused showers, staff should still offer them a shave. The ADON stated she did not think there was a way to document when residents refused a shave. The ADON stated she had just spoke to Resident #182 regarding her facial hair and the resident said to 'go ahead and shave it' since people had kept asking her about it.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/20/2023 at 10:33 a.m., LVN P stated there was a personal hygiene task for documenting shaves on their electronic medical record system but it did not include nail care.</p> <p>During an observation on 9/20/2023 at 10:57 a.m., Resident #182 was observed walking down the 500 hall and smiling. Resident #182's whiskers were then shaved off and she said yes, I got all cleaned up.</p> <p>During an interview on 9/20/2023 at 11:15 a.m., CNA D stated NA N had just trimmed Resident #102's nails but she did not know what prompted her to do so since she was on break.</p> <p>During an interview on 9/20/2023 at 12:09 p.m., CNA E stated Resident #102 refused nail twice on Monday 9/18/2023 but she did not do anything after the resident refused. CNA E said Resident #102 refused nail care with her and she did not work that unit often. CNA E stated the facility kept sheets for nail and shaving, there was a form, it should have been documented, she did not always fill out the form, and she knew it was important. CNA E said she was supposed to report to the oncoming shift when a resident refused but she did not do that Monday (9/18/2023). CNA E stated residents would not feel good and would feel ignored if they wanted their nails trimmed and could not have them trimmed. CNA E said if someone had facial hair that they wanted trim and could not have it trimmed, they would not feel their best.</p> <p>During an interview on 9/20/2023 at 12:17 p.m., CNA E stated chin hair was something they looked out for on shower days, she did not know when the last time Resident #182 received a shave, and she had not noticed Resident #182's whisker hair. CNA E stated CNA C had just shaved Resident #182 that day (9/20/2023).</p> <p>During an interview on 9/20/2023 at 1:33 p.m., NA M said she worked 400 hall on Sunday 9/17/2023 but had to leave around 9:00 a.m. because of an emergency. NA M said no she did not offer Resident #102 a nail trim. NA M stated she was not sure what the schedule was on that hall, she usually worked 200 hall, and that was her first time working with those patients. NA M stated on the 200 hall nail care was done on Sundays and Wednesdays, she was not sure what the schedule was on 400 hall, and she believed it was different on each hall depending on the shower schedule and what their needs were. NA M stated she was not familiar with Resident #102, she just started working for the facility three months ago, and just started working the floor in August 2023.</p> <p>During an interview translated by HHSC translating services on 9/20/2023 at 3:32 p.m., CNA F stated she had provided a shower to Resident #102 on Monday 9/18/2023. CNA F stated yes we do when asked if staff paid attention to facial hair during showers. CNA F stated she did not notice any facial hair on Resident #102 and did not offer to shave her chin. CNA F stated Resident #102 liked to rub her face herself with a towel while in the shower. CNA F stated Sundays were the day staff shaved residents and cut their nails but if she noticed someone had facial hair she would offer them a shave without waiting for Sunday.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/20/2023 at 4:13 p.m., the DON stated nail care was done by CNAs at the time of the shower and residents were shaved on shower days and as needed. The DON stated charge nurses monitored CNAs using shower sheets and CNAs knew they should offer a shave and nail care during showers. The DON stated CNAs should let nurses know if residents refused. When asked how staff were trained on providing nail care, shaving, and dealing with difficult residents, the DON stated staff were educated on how to do it, they did skin checks, were monitored by the ADON and floor nurses, and when we have any issue we start re-in-servicing. The DON stated since Resident #182 had some redness on her face, staff might be afraid to approach her face. The DON stated if staff mentioned they did not feel comfortable trimming Resident #182's hair, her ADON would train them on how to shave her. The DON stated yes that staff should be paying attention to facial hair and nails when showering residents and she would not like it if she had hair on her face. The DON stated Resident #1 refused showers at times but staff should offer to trim her nails even if she refused a shower. The DON stated staff should inform the nurse of the refusal and the nurse should do a progress note. The DON stated if residents had long nails and could not have them trimmed, it would make them feel uncomfortable.</p> <p>During an interview on 9/20/2023 at 5:20 p.m., the Administrator stated direct care staff provided showers, grooming and nail care, and nail care was provided on Sundays. The Asst. Administrator stated floor nurses monitored direct care staff. The Administrator stated yes that residents should be provided options as far as timing and who provided care to them and said residents had the right to refuse. The Administrator stated refusals of nail care and shaving should be documented in residents' care plan and in their kiosk (electronic medical record system).</p> <p>A record review of the facility's in-services from January - September 2023 reflected no in-services on grooming, showers, nail care or shaving care.</p> <p>A record review of the facility's policy titled Activities of Daily Living (ADLs) dated 5/26/2023 reflected the following:</p> <p>Policy:</p> <p>The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.</p> <p>Care and services will be provided for the following activities of daily living:</p> <p>1. Bathing, dressing, grooming and oral care;</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. Conditions which may demonstrate unavoidable decline in ADLs include:</p> <p>c. Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>5. The facility will maintain individual objectives of the care plan and periodic review and evaluation.</p> <p>6. Documentation shall be completed at the time of service, but no later than the shift in which care service occurred.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45830</p> <p>Based on observation, interview and record review, the facility failed to provide or obtain routine dental services to meet the needs of each resident for one (Resident #36) of eight residents reviewed for dental services.</p> <p>SW A failed to obtain financial consent or declination for recommended dental services for Resident #36.</p> <p>This failure placed residents with dental issues at risk of diminished ability to chew, decreased intake and weight loss.</p> <p>Findings included:</p> <p>A record review of Resident #36's face sheet dated 9/20/2023 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of vascular dementia (cognitive decline), iron deficiency anemia, dysphagia (difficulty swallowing), major depressive disorder (depression), cerebrovascular disease (condition affecting blood flow through the brain), schizoaffective disorder (mental disorder), and bipolar disorder (mental illness causing extreme mood swings).</p> <p>A record review of Resident #36's annual MDS assessment dated [DATE] reflected a BIMS score of 9, which indicated moderate cognitive impairment. Resident #36's assessment reflected she had no natural teeth or tooth fragment(s) and was on a mechanically altered diet.</p> <p>A record review of Resident #36's care plan last revised on 9/02/2023 reflected she had oral/dental health problems and a potential nutritional problem. Resident #36's interventions reflected coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>A record review of Resident #36's physician orders reflected she was admitted to hospice on 6/05/2023 and had been ordered a mechanical soft-textured diet since 7/26/2022.</p> <p>During an observation and interview on 9/18/2023 at 3:09 p.m., Resident #36 was observed lying in bed. Resident #36 was observed to be edentulous. Resident #36 stated she did not have dentures, she needed some, and had a little bit of trouble eating. When asked how many teeth she had, Resident #36 stated, not many.</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/20/2023 at 2:25 p.m., SW A stated Resident #36 had a full dental exam on 12/06/2022 and the dentist recommended teeth extraction and dentures for Resident #36. SW A stated they were waiting on a consent form to be signed, Resident #36 was her own RP, and she would be the one to sign it. SW A stated SW B handled consents for treatment. SW A stated he handled initial consents for patients when they came in as new admissions and then all consents after that were handled by SW B. SW A stated SW B was responsible for consents for treatment and she managed the system. When asked how long he expected dentures to be made, SW A stated it was a five step process including extractions, molds/impressions, full fabrication, delivery, test fit and adjustments. When asked if he had any record of Resident #36 being in any process of those steps, SW A said, I don't see one. SW A said, I'm not saying it's prompt or not. SW A stated the facility's next dental visit was scheduled for 9/22/2023 and Resident #36 was not on the list to be treated.</p> <p>During an interview on 9/20/2023 at 2:41 p.m., SW B stated yeah it was her responsibility to obtain consents for treatments but that process changed after she came back from maternity leave in March 2023. SW B stated starting in March 2023, in order to take the load off SW A, obtaining consents for treatment had been all on her instead of both of them. SW B stated she started maternity leave in December 2022 so SW A would have been responsible for getting consent for treatment at that time. SW B said in December 2022, SW A and I were still doing our own floors. SW B stated that in December, she handled treatment consents for the second floor of the facility and SW A handled treatment consents for the first floor. SW B stated based on her record of Resident #36 being seen by the dentist on 12/06/2022, that would have been SW A's responsibility.</p> <p>During an interview on 9/20/2023 at 3:05 p.m., the DON said Resident #36 was a full vendor, which meant she had to pay for her dental work. The DON said, that's a social work thing and administrative thing.</p> <p>During an interview on 9/20/2023 at 3:15 p.m., SW B stated she had just contacted the dental provider and they received a consent for extraction but not a signed payment letter. SW B stated Resident #36 was supposed to get extractions with full upper and lower dentures, which would have cost \$6,300 through Resident #36's insurance and she needed to pay. SW B stated, you have to sign a payment letter saying you're going to pay. SW B said when something like that needs to be done, the dental provider sends a payment letter. SW B stated they sent that payment letter to SW A on 2/23/2023 and when they did not hear back, they sent it again on 3/20/2023. SW B said at that point, the dental provider received a consent for the extraction but no payment letter. SW B stated the dental provider assumed that since the payment was so much, the family would not pay for it and it was too much for them to afford.</p> <p>During an observation and interview on 9/20/2023 at 4:30 p.m., Resident #36 was observed lying in bed and she said yes she wanted dentures even if they cost \$6,000. Resident #36 then said she would have to talk to her parents.</p> <p>During an observation interview on 9/20/2023 at 4:31 p.m., SW A said Resident #36 was her own RP but she had a daughter. SW A stated no ma'am he did not contact Resident #3 or Resident #36's daughter regarding financial consent for the dental treatment. When asked why, SW A said he either didn't receive the consent or didn't see it. SW A said he was not sure if Resident #36 had an actual POA. After scanning his computer system, SW A then said, she does have a medical POA and it's her daughter.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/20/2023 at 4:36 p.m., the DON stated the social workers were responsible for dental care. The DON said in regard to Resident #36, it should have been handled by now. The DON said she was included in emails from the dental provider for emergency treatments but with consents for treatment, she would not have been included on those email chains. When asked how not having dentures could affect Resident #36's ability to chew, the DON said she probably wouldn't be able to chew regular food and enjoy her food.</p> <p>During an interview on 9/20/2023 at 5:20 p.m., the Administrator aid dental services were assigned to social services but the interdisciplinary team was part of it as well. The Administrator stated it could take anywhere from two to four weeks to get dentures but if the resident was a full vendor, they would have to find outside resources. The Administrator stated he was not aware Resident #36 needed extractions and that she did not have the funds for dentures.</p> <p>During an interview on 9/20/2023 at 5:40 p.m., SW B said the dental provider sent consents for treatment to both the facility and to family. SW B said yes it might be buried in someone at the facility's email. SW B said sometimes the administrator or DON were cc'd but someone at the facility would have received the consent.</p> <p>A record review of Resident #36's Annual Exam authored by the DDS dated 12/06/2023 reflected the following:</p> <p>Treatment notes</p> <p>Reviewed Medical History; patient on schedule for annual exam which shows that she still has teeth that need to be extracted (#18-22 and 27-29) are all root tips and should be removed. I am re recommending making her a full upper and full lower denture to replace all missing teeth and help her chew better</p> <p>Action Required by Nursing Home Staff</p> <p>Perform oral hygiene twice daily: morning and evening; Please obtain signature on Consent for Extraction form.</p> <p>Recommended treatment reflected extraction of teeth #18-22 and 27-29, and Fabrication of full upper denture (DFU); Fabrication of full lower denture (DFL)</p> <p>A record review of the facility's policy titled Dental Services dated 10/24/2022 reflected the following:</p> <p>Policy:</p> <p>It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care.</p> <p>Definitions: 'Routine dental services' means an annual inspection of the oral cavity for signs of disease, diagnosis of</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures.</p> <p>'Emergency dental services' includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> <li>1. The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's plan of care.</li> <li>2. Residents and/or resident representatives, during the admission process, are notified of dental services available under the State plan (i.e. state-run programs), and of the potential charges that may apply in the case of routine or emergency dental care provided by outside resources.             <ol style="list-style-type: none"> <li>a. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.</li> </ol> </li> <li>9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record.</li> </ol>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an effective ongoing pest control program for 1 of 1 facility reviewed for pests.</p> <p>The facility failed to have pest control treat the building for insects.</p> <p>These deficient practices placed residents at risk of exposure to pests, diseases, infections, and diminished quality of life.</p> <p>Findings included:</p> <p>Review of Resident #4's face sheet, dated 9/20/2023, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including schizophreniform disorder, essential (primary) hypertension, and other visual disturbances.</p> <p>Review of Resident #4's quarterly MDS assessment, dated 07/11/2023, reflected a BIMS of 00, indicating severe cognitive impairment.</p> <p>Review of Resident #4's quarterly care plan, dated 09/14/2023, reflected he had modified independence, poor decision making skills at times, required cues/supervision for ADLs, and at risk for needs not being met and at risk for decline, high risk for communicable respiratory infections due to age and living in close proximity to others, at high risk for exposure to COVID-19 due to living in close proximity to others and frequent interaction with caregivers and staff, has an ADL self-care performance deficit related to schizophrenia, had a history of behaviors of eating food from trash can's and other residents trays, had a communication problem related to primary language being Vietnamese,</p> <p>Review of Resident #13's face sheet, dated 09/20/2023, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including stage 3A chronic kidney disease, essential (primary) hypertension, blindness to one unspecified eye, spinal stenosis, chronic viral hepatitis C, chronic pain syndrome, major depressive disorder, muscle wasting and atrophy, other lack of coordination, generalized muscle weakness, unsteadiness on feet, other abnormalities of gait and mobility, and age related physical debility.</p> <p>Review of Resident #13's quarterly MDS assessment, dated 07/11/2023, reflected a BIMS of 8, indicating moderate cognitive impairment.</p> <p>Review of Resident #13's quarterly care plan, dated 07/14/2023, reflected he was at high risk for communicable respiratory</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>infections due to age and living in close proximity to others, at risk for signs and symptoms of COVID-19, had history of depression related to major depressive disorder, impaired cognitive function or impaired thought processes related to impaired decision making, long term and short term memory loss, impaired immunity related to asymptomatic human immunodeficiency virus, impaired visual function related to macular degeneration, blindness, an presence of artificial eye, and an ADL self-care performance deficit related to impaired balance, debility, decreased mobility and vision.</p> <p>Review of Resident #141's face sheet, dated 09/20/2023, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including delusional disorders, unspecified dementia, unspecified anxiety disorder, muscle wasting and atrophy, and other abnormalities of gait and mobility.</p> <p>Review of Resident #141's quarterly MDS assessment, dated 09/11/2023, reflected a BIMS of 5, indicating severe cognitive impairment.</p> <p>Review of Resident #141's comprehensive care plan, dated 09/08/2023, reflected she had impaired cognitive function/dementia or impaired thought processes related to dementia and delusional disorder, had limited physical mobility related to weakness, was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits due to dementia, had a communication problem related to dementia, and had an ADL self-care performance deficit related to dementia and delusional disorder.</p> <p>Review of Resident #184's face sheet, dated 09/20/2023, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy, other abnormalities of gait and mobility, other lack of coordination, cognitive communication deficit, need for assistance with personal care, unspecified schizophrenia, and unspecified depression.</p> <p>Review of Resident #184's annual MDS assessment, dated 07/10/2023, reflected a BIMS of 14, indicating she was cognitively intact.</p> <p>Review of Resident #184's comprehensive care plan, dated 07/21/2023, reflected she had an ADL self-care performance deficit related to multiple fractures after being struck by a car, and impaired cognitive function or impaired thought processes related to schizophrenia.</p> <p>During an observation on 09/18/2023 at 09:40 AM, there was a cricket crawling on the ground next to the nursing station on the second floor.</p> <p>During an observation and interview on 09/18/2023 at 10:26 AM, Resident #141 was laying in bed. Resident #141 had a cricket next to her bed. Resident #141 stated there were always insects in residents' rooms.</p> <p>During an interview on 09/18/2023 at 10:58 AM, AA R stated she noticed insects in residents' rooms. AA R stated the facility had a pest control log and reported insects observed, which happened often. AA R stated she observed cockroaches in the facility. AA R stated she observed one cricket on 09/17/2023. AA R stated the facility maintenance staff contacted the pest control company for visits. AA R stated residents quality of life could be affected by the insects in the facility. AA R stated administrative staff were aware of the facility's pest control issue.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/18/2023 at 11:01 AM, CNA I stated pest control came out to the facility on ce a month. CNA I stated residents ate food in their rooms, which may be contributing to the pest control issue. CNA I stated residents' rooms were cleaned every 20 minutes. CNA I stated housekeeping was responsible for cleaning residents' rooms every morning, afternoon, and evening. CNA I stated insects could not negatively affect residents.</p> <p>During an observation on 09/18/2023 at 02:54 PM, there was a fly on the left side of Resident #13's shirt.</p> <p>During an interview on 09/18/2023 at 03:28 PM, Resident #184 stated she seen cockroaches at the facility in residents' restrooms. Resident #184 stated she last seen cockroaches in residents' restrooms two weeks ago.</p> <p>During an observation on 09/19/2023 at 03:34 PM, there were two crickets crawling on the ground in Resident #4's room.</p> <p>During an observation on 09/20/2023 at 09:10 AM, there was a dead cockroach in the facility's elevator across from the first floor's nursing station.</p> <p>During an interview on 09/20/2023 at 12:02 PM, HK Q stated she cleaned common areas in the facility. HK Q stated residents' rooms were cleaned more than once a day. HK Q stated the housekeeping supervisor documented when residents' rooms were cleaned. HK Q stated the housekeeping supervisor informed her and she would observe when residents' rooms needed to be cleaned. HK Q stated staff and residents have complained about housekeeping staff not cleaning residents' rooms. HK Q stated she never observed insects in residents' rooms. HK Q stated she would inform her supervisor if she observed insects in residents' rooms. HK Q stated she observed flies and spiders in the facility. HK Q stated she never received complaints about pest control. HK Q stated she was trained and in-serviced on abuse, neglect, physical environment, dignity, and housekeeping. HK Q stated in-services were given every week or every other week.</p> <p>During an observation and interview on 09/20/2023 at 12:26 PM, there was a cricket crawling on a stack of bedsheets next to Resident #141's bed. Resident #141 stated staff cleaned her room on the morning of 09/20/2023. Resident #141 stated she asked staff in the past to clean her room and they left it as is. Resident #141 stated staff did not clean her room. Resident #141 stated she was bothered by staff not cleaning her room. Resident #141 stated she told staff about the insects in her room and they did nothing. Resident #141 stated she observed cockroaches in her room in the past. Resident #141 stated she last seen a cockroach in her room on 09/19/2023.</p> <p>During an interview on 09/20/2023 at 12:33 PM, CNA H stated she was trained on physical environment, abuse, neglect, and dignity. CNA H stated she observed crickets in the facility, but not in residents' rooms. CNA H stated she never received complaints about insects in the facility. CNA H stated she did not know who was responsible for requesting pest control to visit the facility. CNA H stated staff focused more on residents' care than residents' room. CNA H stated housekeeping staff cleaned residents' rooms twice a day or more if needed. CNA H stated she did not know if residents could be negatively affected by insects in their rooms.</p> <p>During an observation on 09/20/2023 at 12:46 PM, there was a fly in the residents' dining area in the memory care unit.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/20/2023 at 03:52 PM, MA O stated she was trained, in-serviced, and tested on abuse, neglect, physical environment, and dignity. MA O stated she never observed insects in residents' rooms. MA O stated pest control treated the facility three or four times a month. MA O stated housekeeping cleaned residents' rooms once a day or more. MA O stated residents could not be negatively affected by insects.</p> <p>During an interview on 09/20/2023 at 04:22 PM, CNA L stated she never observed crickets or other insects in residents' rooms. CNA L stated pest control treated the facility for insects. CNA L stated she was not sure how often pest control treated the facility. CNA L stated residents could be negatively affected by insects in their rooms.</p> <p>During an interview on 09/20/2023 at 04:31 PM, The Maintenance Director stated he sometimes received complaints about insects. Maintenance Director stated pest control visited the facility once a month. Maintenance Director stated complaints were physically documented on forms and stored in binders and work orders were electronically filed. The Maintenance Director stated pest control last visited the facility twice this past month. Maintenance Director stated he received a complaint about cockroaches and pest control visited the same day the complaint was filed. The Maintenance Director stated no one informed him that there were crickets observed in the facility. The Maintenance Director stated residents could be negatively affected by insects in their rooms.</p> <p>During an interview on 09/20/2023 at 6:50 PM, ADMINISTRATOR stated there was no policy and procedure on homelike environment.</p> <p>Review of the facility's sighting logs from August 2023 through September 2023 reflected the following:</p> <p>Entered: 08/21/2023 Pest sighting description: Roaches on room, walls, and bed 2210 Completed: 08/31/2023</p> <p>Entered: 08/28/2023 Pest sighting description: Roaches room [ROOM NUMBER] Completed: 08/31/2023</p> <p>Entered: 08/29/2023 Pest sighting description: Roaches room [ROOM NUMBER], 2202, 2212, 2312, and 2309 Completed: 08/31/2023</p> <p>Entered: 09/05/2023 Pest sighting description: 501 has ants in room need spray Completed: 09/11/2023</p> <p>Entered: 09/08/2023 Pest sighting description: Baby roaches on 2306 Completed: 09/11/2023</p> <p>Review of the facility's pest control invoices from July 2023 through September 2023 reflected the facility ordered insect light trap rental maintenance on 07/01/2023 and 08/01/2023.</p> <p>Review of the facility's service reports from July 2023 through September 2023 reflected pest control completed the facility's work orders submitted on 07/31/2023, 08/31/2023, 09/11/2023 and 09/18/2023, which included baiting the exterior perimeter for ants, crickets, and large cockroaches, servicing rodent bait stations, inspecting and servicing areas throughout the facility for large and small cockroaches, ants, and flies, treating residents' rooms with liquid application for small cockroaches, and recommending treatments to prevent further pest control issues.</p> <p>(continued on next page)</p>		

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  09/20/2023
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's work orders from August 2023 through September 2023 reflected maintenance staff submitted and completed a work order on 08/08/2023 for cockroaches found in the office area and 09/08/2023 for cockroaches found on the floor in a resident's room.</p> <p>Review of the facility's General Housekeeping Policies, undated, reflected the following:</p> <p>The facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. "Nursing personnel are not assigned to routine housekeeping duties. All housekeeping personnel utilize the accepted practices and procedures to keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and hazards as well as participate in ongoing education and training to maintain or increase their competency. Each occupied resident room is cleaned and put in order daily and as needed. Floors are maintained in good condition and cleaned regularly.</p> <p>Review of the facility's Exercising Your Rights as a Nursing Facility Resident, undated, reflected the following:</p> <p>Your Right to Safety and Quality Care: Freedom From Abuse, Neglect, and Exploitation: You have the right to be free of abuse, neglect, and exploitation. People inside or outside of the facility must not harm you physically or mentally or misuse your property or money. Your facility must:</p> <ul style="list-style-type: none"> <li>o Protect you from abuse, neglect, and exploitation.</li> <li>o Train all staff on how to prevent, identify, stop, and report abuse, neglect, and exploitation.</li> </ul> <p>Safe Surroundings: You have the right to a safe, clean, and comfortable home environment. The facility must:</p> <ul style="list-style-type: none"> <li>o Have enough housekeeping and maintenance staff to keep the building clean and safe.</li> <li>o Clean your room daily.</li> <li>o Have a pest control program.</li> </ul> <p>Quality Care: You have the right to receive all the care necessary for you to have the highest possible level of health. This includes medical care, mental health care, rehabilitative therapies, and supplies. The facility must have enough</p> <p>staff to provide you with care and respond to your needs. Facility staff must be qualified and trained to care for you.</p> <p>Your Right To Be Treated With Dignity and Respect: You have the right to be treated with dignity and respect. You have the right to courtesy and fair treatment from facility staff. Being treated with dignity and respect also means you have the right to make decisions about your life and care. Your facility must respect your choices and preferences.</p>		