| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>49097<br><br>Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 9 of 9 (Resident #292, Resident #12 Residents #6, 17, #22, #27, #60, #93, and 103's) residents reviewed for dignity.<br><br>1. The facility failed to ensure Resident #292, and Resident #12 had a privacy cover on their urinary catheter bag.<br><br>2. The facility failed to promote Residents #6, 17, #22, #27, 60, #93,103's dignity while dining when staff did not serve the residents their lunch tray at the same time as other residents at the same table for lunch on 11/12/2024 and Resident #6 for lunch on 11/14/2024.<br><br>These failures could affect the resident's dignity and affect their quality of life and contribute to poor self-esteem and unmet needs.<br><br>Findings included:<br><br>Resident #6<br><br>Record review of Resident #6's face sheet dated 11/14/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with an admitting diagnosis of unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking, and social abilities), muscle wasting and atrophy (a decrease in size of a body part or tissue) of right and left upper arm, a principal diagnosis of type 2 diabetes mellitus with hyperglycemia (a condition that happens because of a problem in the way the body regulates and uses sugars as a fuel and blood sugars are high), and recent diagnosis of cognitive communication deficit (speech disorder that affects how people use and understand language due to impaired cognition).<br><br>Record review of Resident #6's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating cognition intact.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 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 11/14/2024 |
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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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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #6's care plan revised on 12/30/2029 under ADL self-care performance revealed resident required supervision/tray set up by staff to eat. Revision dated 03/04/2021 revealed resident had a communication problem and was able to make her needs known through verbal communication and responding yes/no to questions. Revision dated 06/16/2023 revealed resident was at risk for weight variance due to dysphagia (difficulty swallowing), anemia, depression, dementia, diabetes, and anxiety.<br><br>Resident #22<br><br>Record review of Resident #22's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with an admitting diagnosis of unspecified dementia, other Cerebrovascular disease (condition that affect blood flow to the brain), muscle wasting and atrophy of both arms and legs, underweight, and adult failure to thrive.<br><br>Record review of Resident #22's quarterly MDS dated [DATE] revealed the resident was unable to complete the brief interview of mental status. Under cognitive patterns, it revealed resident was rarely/never understood. The MDS also revealed that the resident needed assistance with set up and clean up.<br><br>Record review of Resident #22's care plan under ADL self-care performance revealed resident required supervision/tray set up by staff to eat. Revision dated 11/16/2020 revealed resident had impaired communication due to resident's primary language was Vietnamese and spoke minimal English. Resident was able to understand basic commands and directions. Revision on 06/16/2023 revealed resident was at risk for weight variance due to depression, dementia, failure to thrive, and stroke. Resident received regular diet, pureed texture, honey thickened liquids.<br><br>Resident #27<br><br>Record review of Resident #27's face sheet dated 11/14/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with a principal diagnosis of paranoid schizophrenia (type of brain disorder when a person experiences paranoia, delusions, and hallucinations) and admitting diagnoses of type 2 diabetes mellitus with hyperglycemia, spastic hemiplegia (neuromuscular condition of spasticity that results in the muscles on one side of the body being in a constant state of contraction), and delusional disorder (a type of psychotic disorder with the presence of an unshakeable belief in something that is not true).<br><br>Record review of Resident #27's quarterly MDS dated [DATE] revealed a BIMS score of 9, indicating moderately impaired cognition. The MDS revealed that the resident was independent when eating.<br><br>Record review of Resident #27's care plan revised 05/31/2022 under ADL self-care performance revealed resident required supervision/tray set up by staff to eat.<br><br>Resident #93<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #93's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], and 09/23/2024 with a principal diagnosis of encephalopathy (syndrome of overall brain dysfunction), and other diagnoses of vascular dementia, unspecified dementia, schizophrenia, aphasia (disorder that affects language abilities due to brain damage) and dysphagia following cerebral infarction (also known as a stroke when the blood supply to part of the brain is blocked).<br><br>Record review of Resident #93's quarterly MDS dated [DATE] revealed the resident was unable to complete the brief interview of mental status Under cognitive patterns, it revealed resident was rarely/never understood. The MDS also revealed that the resident needed assistance with set up and clean up.<br><br>Record review of Resident #93's care plan revised on 09/24/2024 under ADL self-care performance revealed resident is independent to supervised with setup help only when eating.<br><br>Resident #60<br><br>Record review of Resident #60's face sheet dated 11/14/2024 revealed a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with primary diagnoses of schizoaffective disorder and (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), major depressive disorder (a mental disorder characterized by a persistently low or depressed mood and a loss of interest in normally enjoyable activities), and morbid obesity (a disease involving having too much body fat).<br><br>Record review of Resident #60's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating cognition intact. The MDS also revealed that the resident needed assistance with set up and clean up.<br><br>Record review of Resident #60's care plan revised on 07/08/2021 resident requires supervision with tray setup from staff to eat.<br><br>Resident #17<br><br>Record review of Resident #17's face sheet dated 11/14/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] with a principal diagnosis of unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking, and social abilities).<br><br>Record review of Resident #17's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating cognition intact. The MDS also revealed that the resident needed assistance with set up and clean up.<br><br>Record review of Resident #17's care plan revised on 04/20/2018 revealed resident requires supervision with tray setup from staff to eat.<br><br>Resident #103<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #103's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with an admitting diagnosis of schizoaffective disorder, bipolar type (a mental illness marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, and manic episodes) and principal diagnosis of unspecified dementia (a term used to describe a group of symptoms affecting memory, thinking, and social abilities).<br><br>Record review of Resident #103's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognition intact. The MDS also revealed that the resident needed assistance with set up and clean up.<br><br>Record review of Resident #103's care plan revised on 12/05/2024 revealed resident requires supervision with tray setup from staff to eat.<br><br>Resident #12<br><br>Record review of Resident #12's face sheet dated 11/12/2024 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralyzed), muscle spasm, , urinary tract infection, disorder of urinary system, chronic pain due to trauma, and lack of coordination.<br><br>Record review of Resident #12's Quarterly MDS assessment dated [DATE] reflect a BIMS score of 14 indicating the resident was cognitively intact. The MDS also reflected Resident #12 had an indwelling catheter.<br><br>Record review of Resident #12's care plan dated 07/20/2024 reflected Resident #12 had an indwelling catheter.<br><br>Observation of Resident #12 on 11/12/2024 at 11:11am revealed Resident #12 was laying in her bed. Her catheter bag did not have a privacy cover on it.<br><br>An interview with Resident #12 on 11/14/2024 at 7:41am revealed that normally she had a privacy bag on her catheter. She said she would make sure the staff put one on. She said it bothers her a lot when there was not a privacy bag on her catheter. She said she does not want everyone to see her pee.<br><br>Resident #292<br><br>Record review of Resident #292's face sheet dated 11/12/2024 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of retention of urine.<br><br>Record review of Resident #292's admissions MDS assessment dated [DATE] did not reflect a BIMS score and did not reflect Resident #292 had an indwelling catheter.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #292's care plan dated 11/09/2024 reflected Resident #292 had an indwelling catheter. Interventions included change catheter as needed for leakage or patency, or dislodgment Date Initiated: 11/09/2024 Revision on: 11/09/2024. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date Initiated: 11/09/2024, Revision on: 11/09/2024. Monitor and document intake and output as ordered.<br><br>Date Initiated: 11/09/2024.<br><br>Record review of Resident #292's orders dated 11/08/2024 indicated to monitor for privacy bag placement.<br><br>Observation of Resident #292 on 11/12/2024 at 9:35am revealed the resident was in his bed laying down. Resident #292's catheter bag was connected to the base of the bed without a privacy bag on it.<br><br>Observation of Resident #292 on 11/12/2024 at 3:22pm revealed that Resident #292 was walking down the hall with a staff member and his catheter bag did not have a privacy cover on it.<br><br>An interview with Resident #292 on 11/13/2024 at 2:01pm revealed he had not thought about a privacy bag on his catheter. He said now that he thought about it the catheter should be covered. He said having the privacy bag on the catheter was a respect thing for him.<br><br>An interview with RN A on 11/14/2024 at 8:51am revealed that she had been trained on resident rights. She said catheters were supposed to be checked every day and in a privacy bag. She said the staff are supposed to make sure the catheter bag was always in a privacy bag. She said if a resident did not have a privacy bag on their catheter bag, they may feel embarrassed or ashamed. She said she did not know why Resident #292 and Resident #12 did not have a privacy bag on their catheters.<br><br>An interview with CNA U on 11/14/2024 at 8:58am revealed that she had been trained on resident rights. She said that the catheter was supposed to be always in a privacy bag. She said if a resident did not have a privacy bag it may cause the resident to feel upset or the resident may not want the bag to show. She also said she did not know why Resident #292 and Resident #12's catheters did not have privacy bags. She said normally when they are missing the nurse will replace the privacy bag.<br><br>An interview with the DON on 11/14/2024 at 9:20am revealed she had been trained on resident rights. She said staff are to change the catheter bag as needed and the catheter bag had to have a privacy cover on it. She said the catheter bag should always have a privacy cover on them. She said if the catheter bag did not have a privacy cover on it the resident may feel embarrassed. She stated she did not know why Resident #292 and Resident #12 did not have a privacy bag on their catheters.<br><br>An interview with the DON on 11/14/2024 at 10:50am revealed the facility did not have a policy for catheters.<br><br>An interview with the ADM on 11/14/2024 at 1:15pm revealed he had been trained on resident rights. He stated that staff were supposed to have a privacy cover on all catheter bags. He said catheter bags should always have a privacy cover on them. He stated by not having a privacy bag on a catheter bag could potentially affect the residents dignity. He stated he did not know why Resident #292 and Resident #12's catheters did not have a privacy bag on it.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation of dining services on 11/12/2024 at 12:08 PM revealed that Resident #60 received his meal tray at 12:09 PM while his table mate, Resident #22, did not get her tray until 12:18 PM. Resident #60 had already eaten his lunch.<br><br>During an observation and attempted interview on 11/12/2024 at 12:09 PM, Resident #22 repeated lifted her empty cup up in the air towards the surveyor and patted the table with her hand as she looked at surveyor and around the dining room while waiting for her meal tray. Resident #22 did not respond to questions and only responded, Hi or okay.<br><br>Observation of dining services on 11/12/2024 at 12:16pm revealed Resident #17 received his meal tray at 12:16 PM while his table mate, Resident #27, did not get his tray until 12:28 PM.<br><br>Observation of dining services on 11/12/2024 at 12:17pm Resident #103 received her meal tray at 12:17 PM while her table mates, Resident #93, and Resident #6, did not get their trays until 12:28 PM.<br><br>Observation further revealed that after Residents #60, #17, and #103 got their meal trays, Residents (#22, #27, #93, and #6) sitting at the same table were not served. Staff passed trays to the other residents in the dining room sitting at different tables before they received their meal trays.<br><br>Observation of dining services on 11/14/2024 at 12:06 PM revealed that Resident #60 received his meal tray at 12:06 PM while his table mate, Resident #6, did not get her tray until 12:14 PM. Observation further revealed that after Resident #60 got his meal tray, staff passed trays to the other residents in the dining room sitting at different tables before Residents #6 received her meal tray.<br><br>During interviews with Residents #93, #6, and #27 on 11/12/2024 at 12:30 PM revealed Resident #93 did not like that she was served her meal tray late as she was hungry. Resident #6 stated it was okay that she received her lunch tray after her table mate. Resident #27 stated that it did not bother him, and it happened all the time that residents sitting at the same table did not receive their meal trays at the same time.<br><br>An interview with CNA O on 11/14/2024 at 09:24 AM revealed he had been trained on resident rights. There was a policy about passing meal trays that explained putting bids on residents, helping feed them, and hand hygiene. CNA O stated that was important for residents sitting at the same table to receive their meal trays at the same time so that they felt important, like they were a priority and not forgotten by staff.<br><br>An interview with ADON C on 11/14/2024 at 09:45 AM revealed she had been trained on resident rights. The facility's policy on meal service regarding dining tray pass was that all residents sitting at the same table get their trays before moving on to the next table. Residents sitting at the same table watching other residents eat could make them uncomfortable or feel like they had forgotten to give them their food. It was also a dignity issue. ADON C stated that when she helped with meal service, she would ensure dining trays were passed according to policy.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with CNA N on 11/14/2024 at 11:21 AM revealed dining trays should be passed according to seat assignments. Residents sitting at the same table need to be served at the same time because it was good manners. Also, a resident that was hungry might reach for another resident's food and that was a safety concern if the resident got food that was not consistent with their diet. CNA N stated it could be a dignity issue with sitting there watching another resident eat, especially if the other resident was hungry.<br><br>An interview with the DON on 11/14/2024 at 03:36 PM revealed she had been trained on resident rights. The facility's policy on dining tray pass was that all residents sitting at the same table get their trays before moving on to the next table. The DON stated it was a dignity issue of not getting meal trays at the same time and this would not meet her expectation.<br><br>An interview with the ADM on 11/14/2024 at 04:17 PM revealed the facility's policy on meal service dining tray pass was standard and all residents sitting at the same table get their trays before moving on to the next table. The ADM stated, It's a dignity issue and we all know better. It was not a homelike environment and did not meet his expectations. He stated that he did not know why the residents did not get their meal trays together.<br><br>Record review of Incontinence care Proficiency Checklist with or without Foley (not dated) revealed assure drainage bag is in a privacy bag (this also protects from contamination).<br><br>Record Review of Meal Service Policy dated 12/01/2011 revealed All residents at one table are served at the same time prior to serving residents at other tables.<br><br>50176 |

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F 0557

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176

Based on interviews, and record review, the facility failed to ensure residents had the right to be treated with respect and dignity for 12 of 12 residents 9 confidential residents and 3 of 3 residents (Residents #128, Resident #140, Resident #101) reviewed for resident rights.

1. The facility failed to ensure the SS did not search residents' wheelchairs and belongings (Resident #128, #101, and #140) for contraband without their permission.

2. The facility failed to ensure an unidentified staff did not conduct random searches on residents' rooms (Residents #128, Resident #140, 9 confidential residents) on undisclosed dates without residents' permission or remove items from their rooms without permission.

This failure could place all residents at risk of emotional distress, feelings of disrespect, lack of dignity, and could decrease residents' self-esteem and/or quality of life.

Findings included:

Resident #128

Record review of Resident #128's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] and 03/01/2024 with a principal diagnosis of fusion of the spine. Her other diagnoses included, Chronic Obstructive Pulmonary Disease (COPD- an ongoing lung condition caused by damage to the lungs), dementia (a term used to describe a group of symptoms affecting memory, thinking, and social abilities) muscle wasting and atrophy (a decrease in size of a body part or tissue), and need for assistance with personal care.

Record review of Resident #128's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognitively intact.

Record review of Resident #128's care plan revised on 11/13/2023 revealed resident was a smoker and would not smoke without supervision. Interventions included instruct resident about smoking policy on locations, times, and safety concerns.

Record review of Resident #128's progress note dated 10/10/2024 created by SS revealed:

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This social worker was in the front lobby when this resident and her roommate were headed outside. It is a well-known fact that when a resident that smokes go out at this hour they are going out to smoke and will have a lighter and cigarettes on them. This resident did and refused to hand them over when asked to. She did not deny having these prohibited products on her. She stated that she was going to smoke off the property. Social worker reminded her that on August 5, 2024, she signed the Smoking/Tobacco/Vaping Acknowledgment which states .Under no circumstances will smoking materials .be allowed to be kept in the resident's room OR ON THEIR PERSON. Social worker took the items out of the back pouch of her wheelchair. She yelled and cursed. Social worker followed her outside and gave her 2 cigarettes (1 for her the other for the roommate}. After she lit her cigarette social worker requested that she give social worker the lighter. She cursed and yelled at social worker, who let her keep the lighter rather than argue with her or listen to her vicious profanities. This social worker was adhering to the policies of this facility.<br><br>During an interview on 11/12/2024 at 03:19 PM, Resident #128 stated the SS had searched her person, pockets, belonging, and wheelchair, on several occasions, without her permission. The SS told the resident she was searching for cigarettes and contraband. Resident #128 stated she knew she could not have cigarettes or a lighter in her room and stated she stashed these items next door at an abandoned building for her use in the evenings off premises. There was an incident on 10/09/2024 when the SS grabbed cigarettes out of resident's hands when returning from a smoke visit and in the process, bend the resident's glasses, and now her glasses do not fit correctly. Resident #128 reported it to the ADM, and she showed the surveyor copies of text message sent to the ADM. Resident #128 stated these searches made her feel embarrassed, harassed, angry, and singled out.<br><br>During an interview on 11/13/2024 at 07:46 AM, Resident #128 clarified that her allegation of assault against the SS had occurred off property. However, these searches occurred on property while trying to exit and enter the facility. Resident #128 stated that she felt sad, depressed, angry, and it made her cry. Her depression was worse. She felt like she was not wanted at the facility and worried that the SS would not help her anymore. Resident #128 worried about filing a complaint for fear of retaliation. On 10/30/2024, the SS had followed her outside of the facility and told the resident she had to sign a 30-day eviction notice. Resident #128 stated she told the SS that she would sign the eviction notice but would write on the notice that the SS had been stalking them off property. When she returned to the facility, she asked to sign the eviction notice and the SS threw up her hands and said never mind. The SS was getting out of control. Resident #140 was also present during the interview and recalled the incident as well. Resident #140 stated that she was upset and cried. She felt like no one cared about her and she was not wanted at the facility. She stated the SS treated her like a child.<br><br>Resident #101<br><br>Record review of Resident #101's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a principal diagnosis of cerebral infarction (stroke occurs when the blood supply to part of the brain is blocked or reduced). Her other diagnoses included, muscle wasting and atrophy (a decrease in size of a body part or tissue), need for assistance with personal care, and history of falling.<br><br>Record review of Resident #101's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognitively intact.<br><br>(continued on next page) |

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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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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #101's care plan revised on 11/13/2023 revealed resident was a smoker and would not smoke without supervision. Interventions included to notify charge nurse immediately if it was suspected resident had violated facility smoking policy.<br><br>Record review of Residents #101 progress notes from 7/01/2024 to 11/13/2024 did not reveal any mention of concerns with the smoking policy or refusal for search.<br><br>Record review of Resident #101 progress and nurse's notes from 06/13/2024 to 11/13/2024 revealed no incidents or concerns with the smoking policy.<br><br>During an interview on 11/14/24 at 09:11 AM, Resident #101 stated in August 2024, the SS searched her wheelchair, without her permission, because resident was caught smoking pot outside. When resident came back into the facility around 8:30 PM, the SS thought she had marijuana on her, and the SS searched the back of her wheelchair. The SS did not say anything to Resident #101 and did not ask her if it was okay to search her. Resident #101 was very upset, and it made her mad and feel bad. Resident #101 denied that she had marijuana on her and only had one cigarette in her cigarette case. The SS took resident's cigarette case and resident knocked the box out of the SS's hand and picked up the box. Resident #101 stated that the SS told her, You're gone. I'm going to request that you get moved. Resident said the SS reported the incident to the ADM and the ADM told the resident not to worry about it; that she would not be moved; and that the SS should not be searching her. Resident #101 stated that it has not happened again, but she had heard other residents talk about being searched by the SS without their permission but could recall any of the residents' names.<br><br>Resident #140<br><br>Record review of Resident #140's face sheet dated 11/14/2024 revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Her diagnoses included dementia, other psychoactive substance abuse with psychoactive substance-induced mood disorder, bipolar disorder, mild cognitive impairment, and need for assistance with personal care.<br><br>Record review of Resident #140's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognitively intact.<br><br>Record review of Resident #140's care plan revised on 07/17/2023 revealed resident was a smoker and would not smoke without supervision. Interventions included instruct resident about smoking policy on locations, times, and safety concerns.<br><br>Record review of Residents #140 progress notes from 07/01/2024 to 11/13/2024 did not reveal any mention of concerns with the smoking policy or refusal for search.<br><br>During an interview on 11/12/2024 at 03:19 PM, Resident #140 stated that she was a witness to the incident with Resident #128. Resident #140 stated that she too had been searched by the SS when exiting and entering the facility. Resident #140 stated that she and her roommate leave cigarettes and a lighter in a hiding spot next door at the abandoned building for her use when off premises because she knew she could not have those items in her room. Resident #140 stated that these searches made her feel embarrassed, harassed, angry, and singled out. Resident #140 now left her purse in her room for fear that it will be searched when she returned to the facility.<br><br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/12/2024 at 03:54 PM, the ADM stated that the facility had cameras, but they were not in use. There was an incident with Resident #120 and #140 in October 2024 when they complained that the SS followed residents out of the facility and took the cigarettes out of Resident #128's hand. Their facility policy stated that the residents cannot have cigarettes in the facility. Those two residents were leaving their room and had cigarettes in their hands, which was against facility policy. Those residents bring in illegal substances. The ADM stated that the SS put a progress note in Resident #128's file about the incident.<br><br>During the resident council meeting on 11/13/2024 at 11:31 AM, 9 confidential residents raised their hands to indicate that their rooms had been searched by facility staff at undetermined dates without their consent. Residents stated that staff do random searches of residents' rooms without their permission. During the resident council meeting, 1 of 9 confidential residents stated that an unidentified staff member in blue scrubs came into her room about two weeks ago and searched her belongings and her roommate's belongings in their drawers without her permission. Her roommate was not in the room. The staff member stated they needed to clean up the room before State arrived. On another occasion, an unnamed CNA went through her closet and took clothes without her permission. The unnamed CNA told the resident that the clothes would not fit her, and she did not need them. This made the resident very angry because these were clothes and items, she received from family members and other visitors that came to see her. 1 of 9 confidential residents reported this to the ADM and DON and was told they would investigate it, but nothing happened. 2 of 9 confidential residents stated that an unidentified staff member came into his room without permission and took items (toiletries and clothing) that he bought and give it to another resident without his permission. That made him mad because he paid for those items, and they were his.<br><br>3 of 9 confidential residents stated that an unnamed CNA had come into her room on an unidentified date without permission and took incontinence supplies (diapers/briefs) that her family member bought for her and gave it to another resident without her permission. That made her upset because her family member paid for those and they were meant for her, not another resident.<br><br>4 of 9 confidential residents stated that several staff members on different dates have search her shopping bags, without permission, when she came back into the facility after going to the store. Her room was searched last week. 4 of 9 confidential residents stated that she knew her room was searched when she was not there because when she returned, items in the room had been moved around. She stated that staff were looking for contraband items such as cigarettes and lighters. 5 of 9 confidential residents stated that the SS had searched her body, clothes, and purse without her permission.<br><br>During an interview and record review on 11/13/2024 at 12:02 PM, the ADM provided the State surveyor with a copy of an investigation note. The ADM stated that the incident that was investigated involving Resident #128 and the SS on 10/09/2024, which had occurred on site in the facility. The front desk receptionist was a witness. The ADM stated that Resident #128 changed her narrative of what happened and told the surveyor to review the progress note in the resident's file. The ADM stated residents were asked if they have any prohibited items in their possession, but they are not searched unless the resident consents. Staff do not take items away from the residents, but rather, residents were encouraged to give the facility the items, such as cigarettes and lighters. If the resident refused, then they would deal with it in an Interdisciplinary team meeting. The ADM stated residents' rooms were searched when the resident gave consent. The ADM was not aware of any facility policy regarding searching the residents.<br><br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the investigation note revealed the ADM had received a text message on 10/09/2024 at 9:27 PM from Resident #128 that the SS had assaulted her. On 10/10/2024, the ADM had contacted Resident #128 and told her an investigation would be completed with police notification. Resident #128 did not want the police notified. Resident #128 stated that the SS did not touch her. Her feelings were hurt when the SS took away her cigarettes and she only wanted her cigarettes returned to her. On 10/11/2024, the ADM met with Resident #128 in his office and Resident #128 stated she was fine, the SS did not touch her when the SS took away the packet of cigarettes. A witness statement was provided by the RECP that on 10/09/2024 at appropriately 8:45 PM, Residents #128 and #140 came downstairs to go outside to smoke and the SS said, It (sic) you have cigarettes in your possession, you need to turn them over to me, and once you turn them over to me you will need to sign this form stating that you know the smoking policy. The residents went back upstairs and returned to the lobby about 15 minutes later. As they were going outside, the SS saw the cigarettes in the back pocket of Resident #128's wheelchair. The SS reached inside Resident #128's wheelchair pocket and Resident #128 reacted by swinging at the SS and calling her all kinds of derogatory words. Resident #128 did not consent to the search and Resident #140 told the SS, You must be crazy if I let you search me.<br><br>During an interview on 11/13/2024 at 03:14 PM, the SS denied searching any resident without permission. The SS stated she asked residents if she could search their bags, but if they said no, she respected that and said, no problem, I'll see you later. Residents offer to give her cigarettes and hand them to her. The SS denied taking anything from the residents. The SS was not aware of any facility policy regarding searching the residents. The SS stated she had never taken anything out of a resident's wheelchair.<br><br>When asked about the incident with Resident #128, the SS could not recall the specific date, but stated it was in the evening about a month ago in October 2024 when Residents #128 and #140 came back inside the facility, after being outside and Resident #128 said SS scratched her and was going to call the State. The SS stated nothing happened. The residents went upstairs and returned to their room. The SS went upstairs and asked the nurse to do a skin assessment, which was refused. When the surveyor asked the SS about the progress note in Resident #128's file, the SS said she took something out of the resident's wheelchair, but then stated maybe she looked at some paper but did not take anything out of the wheelchair. The SS denied ever taking cigarettes away from Resident #128. The SS stated that there were no cigarettes involved in this incident. She informed the DON of the incident. The SS stated she was very surprised to learn Resident #128 had a problem with her. The SS repeated stated, Why would I risk my license? She denied searching any residents without permission.<br><br>Record review of Resident #128's electronic medical file did not show any skin assessment or refusal in October 2024.<br><br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/13/2024 at 05:08 PM, the RECP stated she saw the SS searched the back pocket of Resident #128's wheelchair without the resident's consent. It made Resident #128 very mad, and resident screamed and cursed at the SS. The RECP stated that the SS searched the back of the wheelchair, but did not find any cigarettes, only some papers. The RECP stated that the SS would stand in the lobby and searched residents without their consent. The RECP reported it to the DON and her supervisor. She stated that the ADM talked to her yesterday (11/12/2024) about the incident between SS and Resident #128 on 10/09/2024 and asked her to write down a statement. The RECP stated that in August of 2024, the SS searched Resident #101 without her consent. Resident #101 was smoking marijuana outside and when the resident came back inside the facility, the SS asked for the marijuana and Resident #101 told her no. The SS searched Resident #101's wheelchair without her consent and found marijuana and cigarettes and kept them. The resident was extremely upset and said, You can't do that. The RECP reported it her supervisor, the DON, and the ADM. The ADM made a joke about it and said, why can't she smoke marijuana to help her sleep? The RECP stated that she was told by the ADM and her supervisor that only the SS could search residents.<br><br>During an interview on 11/14/2024 at 09:24 AM, CNA O stated that residents' wheelchairs and rooms (bed, closet, dresser drawers) were searched by staff if they suspected the resident had contraband or the room smelled like cigarette smoke. CNA O reported to the nurse, who then would talk to the resident and ask permission to search their room.<br><br>During an interview on 11/14/2024 at 09:45 AM ADON C stated that she was not sure if the facility had a policy about searching a resident. ADON C asked permission to search residents belonging because the residents cannot have cigarettes or lighters for their own safety. Usually, residents will allow her, and she had never had a resident refuse.<br><br>During an interview on 11/14/2024 at 10:22 AM, the SW stated she was not sure about the facility's policy about searching a resident. She had never searched a resident without their consent, and she had never had a resident refuse.<br><br>During an interview on 11/14/2024 at 03:36 PM, the DON stated she had been trained on resident rights. She stated the facility does not have a policy on searching residents. The DON stated they ask residents for permission to search. If the resident refused, they would get another staff member involved to convince the resident to comply with the search. If the resident was suspected of having contraband and would not consent to a search, then they called the police. If the resident refused a search, it must be documented in the resident's chart under nurses' notes. The DON stated that Resident #128 accused the SS of searching resident without her consent. The SS took cigarettes out of her hand while on property in the parking lot. The DON stated that she was not aware of the incident with Resident #101. This behavior would meet her expectations.<br><br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/14/2024 at 04:17 PM, the ADM stated that the facility had no policy for searching residents. The ADM stated that these residents have a history of bringing in illegal substances. The ADM stated that they ask the residents to give the facility the drugs, cigarettes, lighters, or other contraband that it is obvious these residents have contraband on them. The ADM stated they generally get consent before searching and if a resident refused, it would be documented in the resident's progress notes. Regarding Residents #128. #101, and #140, the ADM stated they have a history of bringing in illegal drugs. The ADM stated that the SS saw cigarettes inside Resident #128's wheelchair and the SS took the cigarettes away. The ADM stated that Resident #101 was very combative. The ADM was not aware of an incident with Resident #101 being searched, but that Resident #101 had violated the smoking policy and was smoking marijuana outside and she (Resident #101) naturally got upset when we tried to take her marijuana. The ADM stated these residents are not your grandmas and grandpas that live here. We search their rooms and these residents. The ADM stated that illegal drugs were brought into the facility and said, We get it out and we do get the police involved. The ADM asked, What the hell are we supposed do? The ADM stated that he dealt with it by searching the residents, their belonging, and their rooms without their consent. The ADM stated, I don't believe that's a resident right. How is that their right? We are doing just what a reasonable person would do to keep residents safe.<br><br>Review record of the facility's policy titled Promoting/Maintaining Resident Dignity dated 01/13/2023 revealed:<br><br>Policy:<br><br>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, which maintains or enhances resident's quality of life by recognizing each resident's individuality.<br><br>Compliance Guidelines:<br><br>11. Respect the resident's living space and personal possessions. At no time will staff search a resident's body or personal possessions without consent from the resident, or if applicable, the resident's representative. The resident or representative must understand the search is voluntary and why the search is being conducted. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001<br><br>Based on observation, interview and record review, it was determined the facility failed to provide personal privacy for of closing privacy curtains during pericare for resident ( Resident # 92) reviewed for privacy. 1 of 1 resident was observed.<br><br>Resident #92's privacy curtain was not closed all the way while receiving incontinent care.<br><br>This failure could place residents at risk not having personal privacy.<br><br>Findings included:<br><br>Review of Resident #92's Face Sheet dated 11/13/2024 revealed he was a [AGE] year-old male who was admitted to the facility with and initial admitted [DATE] and an admitted [DATE]. Resident #92's diagnoses included unspecified dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (, mood disturbance, anxiety, hemiplegia, hemiparesis following nontraumatic subarachnoid are a group of serious mental illnesses that all have signs of psychosis) hemorrhage (term used to describe blood loss) affecting right dominant side, personal history of traumatic brain (injury usually results from a violent blow or jolt to the head or body) , paranoid schizophrenia (subtype of schizophrenia that experts no longer recognize), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and aphasia (is a disorder that affects how you communicate).<br><br>Record review of Resident #92's MDS dated [DATE] revealed that Resident #92 had a BIMS score of 15 indicating the resident could understand and make self-understood all the time.<br><br>Review of the Care Plan for Resident #92 problem onset dated 05/14/2021, reflected; Resident is incontinent of bowel and bladder at risk for impaired skin integrity. Resident will remain free from alterations in skin integrity through the next review date. C.N.A's to apply barrier cream as needed after incontinent episodes. ADLs indicate: providing pericare, assisting with baths etc.,<br><br>In an observation on 11/13/2024 at 4:05 p.m., CNA H gathered his supplies and closed the door to the room and closed the privacy curtain in between the residents beds halfway. Resident #92 roommate was sitting in his wheelchair in front of his TV which was on at a very high tone, watching TV. CNA H began to provide incontinent care for Resident #92, but he never closed the front curtain in front of Resident #92 bed, and he never fully closed the curtain in between the beds. During incontinent care Resident #92 was rolled over to his right side and he was instructed by CNA H to hold on to the rail, at that point Resident #92 reached over and grabbed the middle privacy curtain and tried to close it all the way to provide more privacy for him during incontinent care.<br><br>In an interview on 11/13/2024 at 4:29 p.m., Resident #92 verbalized that staff close the curtains sometimes when they are providing incontinent care. Resident #92 stated when the privacy curtain was not pull it made him feel not good.<br><br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 11/13/24 at 4:32 p.m., CNA H stated when asked why he did not close the front curtain while providing incontinent care he stated I was supposed to close it. Every time we change the resident, we are to close it for privacy. CNA H stated he closed the curtains all the way.<br><br>During interview on 11/14/2024 at 9:50 a.m., Resident #92 stated No, I need privacy when he getting incontinent care.<br><br>In an interview on 11/14/24 at 2:09 p.m., the DON stated staff should be closing the door and pulling the privacy curtain when providing incontinent care. She stated it could make the residents uncomfortable if staff do not close the door and curtains.<br><br>Record review of the in-services Privacy of resident indicated the following:<br><br>* 07/17/2024-Make sure divider curtain in the resident room will be closed when doing incontinent care to the resident door must be closed<br><br>*08/14/2024- Make sure divider curtain in the resident room will be closed when doing incontinent care to the resident door must be closed.<br><br>*09/14/2024-Proper Procedure for quality resident care (Peri care, Privacy, Dignity, Infection Control).<br><br>Review of the Perineal care Policy dated 10/24/2022 stated, .<br><br>Policy Explanation and Compliance Guidelines:<br><br>5. Provide privacy by pulling privacy curtain or closing room door if a private room. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176<br><br>Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for the rooms of 4 of 20 residents (Resident room [ROOM NUMBER], #43, #106, and #176) reviewed for cleanliness and sanitization.<br><br>The facility failed to ensure that the rooms of Residents #12, #43, #106, and #176 were thoroughly cleaned and sanitized.<br><br>This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.<br><br>Findings included:<br><br>Resident #12<br><br>Review of face sheet dated 11/13/2024 for Resident # 12 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her primary diagnoses were quadriplegia (paralysis of all four limbs and the torso), cerebral palsy (a group of conditions that affect movement and posture), and Cauda equina syndrome (severe type of spinal stenosis where all the nerves in the lower back suddenly become severely compressed).<br><br>Review of Resident # 12's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 reflecting intact cognition. Resident # 12 had impairment on both sides of the lower extremity (hip, knee, ankle, foot) and required total assistance for ADL care of toileting hygiene, shower/bathe self, dressing, and transfers.<br><br>Review of Resident # 12's Comprehensive Care Plan dated 08/26/2024 reflected an ADL self-care performance deficit related to history of multiple fractures, quadriplegia, cerebral palsy with interventions for bathing/showering, dressing, mobility, transfers, toileting, and personal hygiene with total assistance required.<br><br>During an observation and interview on 11/12/2024 at 11:11 AM of Resident #12 stated that the flies were bad. Resident kept swatting at a fly in the room throughout interview.<br><br>Resident #43<br><br>Record review of Resident #43's face sheet dated 11/14/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included bipolar disorder (a mental disorder that causes extreme mood swings) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations.<br><br>Record review of Resident #43's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating cognition intact.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident # 43's Comprehensive Care Plan revised 08/28/2024 reflected an ADL self-care performance deficit related to aspiration pneumonia and COPD with interventions for bed mobility, eating, transfers, and toileting, with supervision X1 staff assistance required. Resident had bladder incontinence due to impaired mobility.<br><br>During an observation on 11/12/2024 at 09:34 AM Resident room [ROOM NUMBER] was cluttered with dirty clothes on the bed and floor, and containers of opened and unopened food (soup cans, chips, bread, crackers, cookies) were on all surfaces in room and on the floor. A soiled hospital gown was on floor. Luggage, plastic shopping bags, bottles of water and other drinks, and stuffed animals were on the floor. Random boxes and an opened bag of briefs were piled on top of the luggage. The trash can in the bathroom was full of trash.<br><br>During an interview on 11/12/2024 at 09:34 AM Resident #43 stated she asked the CNAs for help cleaning her room and no one had helped her. The resident wanted to leave the facility due to the situation. She had recently returned from the hospital due to COPD and was on oxygen.<br><br>During an observation and interview on 11/14/2024 at 11:11 AM Resident #43 stated that she requested assistance from the CNAs with cleaning and organizing her room and no one had helped her. It had been several days since her request. The CNAs told her they were too busy to help clean and the dirty room and clutter made her feel claustrophobic. The room was cluttered with clothes on the floor and on the bed. On the floor, there were wipes, bottles of water and Gatorade and other drinks, books, stuffed animals, plastic bags, food, shoes, oxygen tubing, and some kind of machine/medical equipment.<br><br>An interview with CNA O on 11/14/2024 at 11:31 AM revealed Resident #43 had asked him to help clean and organize her room on 11/13/2024 or before. CNA O stated he had not helped her yet but would later.<br><br>During an observation on 11/14/2024 at 02:16 PM Resident #43's room was cluttered and had not been clean. Clothes were on the floor and on the bed. On the floor there was a box of Christmas decorations, wipes, bottles of water and Gatorade and other drinks, books, stuffed animals, plastic bags, food, shoes, oxygen tubing, and some kind of machine/medical equipment.<br><br>Resident #106<br><br>Record review of Resident #106's face sheet dated 11/14/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosed included major depressive disorder.<br><br>Record review of Resident #106's quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognition intact.<br><br>Review of Resident # 106's Comprehensive Care Plan revised on 08/31/2024 reflected an ADL self-care performance deficit related to impaired balance, history of amputation to left leg, convulsions, chronic pain, hypertension, PTSD (a mental health condition that can develop after someone experiences or witnesses a traumatic event), and CAD (coronary artery disease) with interventions for bathing/showering, bed mobility, transfers, and toileting, with some supervision or set up required, but was able to carry out tasks for self.<br><br>(continued on next page) |

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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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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 11/12/2024 at 11:56 AM Resident #106's room, bed linens were dirty and stained with only a sheet, no blanket, and no pillowcase. The pillow was also dirty, and the room smelled like cigarette smoke. Resident stated he would like a clean pillowcase, blanket, and sheet. The resident kept falling asleep during the interview, and additional information could not be obtained.<br><br>Resident # 176<br><br>Review of face sheet dated 11/13/2024 for Resident # 176 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder bipolar type, PTSD, depressive disorder, anxiety disorder, muscle wasting and peripheral vascular disease.<br><br>Review of Resident # 176's Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Resident # 176 had impairment on one side of the lower extremity (hip, knee, ankle, foot). Resident # 176 required supervision or touching assistance for ADL care of toileting hygiene, shower/bathe self, and transfers. Resident # 176 was occasionally incontinent of bladder and frequently incontinent of bowel.<br><br>Review of Resident # 176's Comprehensive Care Plan dated 10/22/2024 reflected an ADL self-care performance deficit related to impaired balance, limited mobility, limited ROM, pain (L-foot) with interventions for bathing/showering, dressing, and oral care with assistance required. Resident # 176 had the need for enhanced barrier precautions due to surgical wound on the top of the left foot and was at risk for infection and decline in physical activity. Interventions in place included gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care, wound vac), with no room restrictions.<br><br>During interview on 11/12/2024 at 11:24 AM with Resident #176 stated the housekeeper does not clean the room. Resident stated they must ask to get their room cleaned. Resident stated the baseboard was coming off the bathroom wall and this was where the roaches crawled out from. Resident stated linens were only cleaned when State came into the facility and when linens were changed, they received linens with stains and holes. Due to Resident's recent toe amputation and the dirty room, the resident was afraid to walk on the floor. Observation of resident's room revealed room to be cluttered and baseboard in bathroom had come loose from the wall.<br><br>An interview with RN P on 11/14/2024 at 02:50 PM revealed he was not aware that Resident #43 had asked for someone to clean/organize her room. He stated that CNAs and housekeeping should clean the room daily. RN P stated that requests for help from residents should be responded to As soon as possible and the delay with CNA O would not meet his expectation. He did not have any concerns for the resident's safety.<br><br>An interview with the DON on 11/14/2024 at 03:36 PM revealed she had been trained on resident rights. The facility's policy was that housekeeping and staff should clean resident's rooms daily. If a resident requested help from her, she would assign it to staff. Resident #43 had requested help with cleaning her room in the past, but not recently. The DON stated that her expectation was that staff would help a resident as soon as possible. The DON stated a cluttered room was not homelike and a CNA not helping the resident clean their room would not meet her expectation.<br><br>(continued on next page) |

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| Heritage Park Rehabilitation and Skilled Nursing C | 2806 Real St<br>Austin, TX 78722 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with the ADM on 11/14/2024 at 04:17 PM revealed ADM stated that staff should provide cleaning assistance to the residents. Clutter in the room was not homelike and he would expect staff to aid residents within a reasonable time frame.<br><br>Review of facility's policy named General Housekeeping Policies undated stated: Each occupied resident room is cleaned and put in order daily and as needed.<br><br>Review of facility's policy named Promoting/Maintaining Resident Dignity dated 01/13/2023 stated: Respond to requests for assistance in a timely manner. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were free from any physical restraints imposed for purposes of convenience and not required to treat the resident's medical symptoms for 1 (Residents #6) of 37 residents reviewed for restraints.<br><br>The facility failed to ensure that wedges (triangle plastic pads used to position residents with pressure ulcers) were not used on the side of Resident # 6's bed without the resident having been evaluated for the medical need.<br><br>This failure could result in residents having physical restraints used that limited their movement without being evaluated for the medical need.<br><br>Findings include:<br><br>Record review of Resident #6's face sheet dated 11/14/2024 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dementia (memory, thinking, difficulty), bipolar (extreme mood swings), major depressive disorder, , cognitive communication deficit (problems with communication) and muscle wasting.<br><br>Record review of Resident #6's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 indicating Resident #6 was cognitively intact. The MDS also indicated Resident #6 was dependent on staff for transfers and maximal assist for bed mobility. The MDS also revealed that Resident #6 had an actual fall, and the facility was assessing for fall risk.<br><br>Record Review of Resident #6's Care Plan dated 10/31/2024 did not have anything on it for wedges to be used.<br><br>Record Review of Resident #6's orders revealed that there were no orders for the Wedges.<br><br>Observation of Resident #6 on 11/12/2024 at 10:45 am revealed the resident was laying in her bed moving around. Resident #6 had two triangular wedges on her bed preventing her from getting off the bed.<br><br>Observation of Resident #6's peri care on 11/13/2024 at 9:54am revealed that the resident did not have a pressure ulcer.<br><br>An interview with Resident #6 on 11/12/2024 at 2:28pm revealed she did not want to answer any questions about the wedges on her bed. She said the staff treat her good.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An Interview with LVN W on 11/14/2024 at 12:44pm revealed that she had been trained on resident rights. She stated that the facility was a no restraint facility. She said a restraint was anything that restricted the resident's from doing everyday things. She said that the facility used the plastic triangular wedges to position the resident's in their bed when they have a pressure ulcer. She said when using a restraint or a wedge the facility was supposed to have the resident assessed and a doctor order before using. She said if a resident were restrained it could affect them mentally and they may think they were being held against their will. She said she did not know why Resident # 6 had the wedges on her bed . She said staff should not of had the wedges.<br><br>An interview with CNA O on 11/14/2024 at 12:52pm revealed he had been trained on resident rights. He said the policy for restraints was staff could not put anything that would cause the resident to be stuck in one place. He said bedrails and ties were restraints. He said that the plastic wedges were used to protect residents from falling of the bed. He said he did not know if staff needed a doctor's order for the wedges. He said if a restraint was used on a resident, they may feel trapped. He said that Resident #6 moved a lot and the staff put the wedges there so she would not fall off the bed. He said there was no pass down (report from the leaving staff about residents) on the wedges being used and that they were already on the resident's bed.<br><br>An interview with the DON on 11/14/2024 at 1:03pm revealed she had been trained on resident rights. She said that the facility did not have restraints because it was a no restraint facility. She said a restraint was side rails and anything that prevents the resident from moving. She said wedges are used to position the resident when they have a pressure ulcer. She also said the facility had to have a doctor order before a restraint could be used. She said if staff used restraints, it could cause more injury to the resident. She said she did not know why staff were using the plastic wedges to keep the resident from falling.<br><br>An interview with the ADM on 11/14/2024 1:36pm revealed he had been trained on resident rights. He stated the facility was a zero-restraint facility. He said a restraint was anything that restricts a resident's movement. He said that the plastic triangular wedges were used to position the resident in the bed when they had a pressure sore. He also said when staff use the wedges for positioning the facility would get a doctor order. He said the negative of using restraints could potentially affect the resident's ability to move freely. He said he did not think staff understood the fall policy and intended to protect her.<br><br>Record Review of Resident #6's medical chart and orders did not have anything in it for the use or consent of the wedges.<br><br>Record review of the Restraints Policy dated 08/15/2022 revealed the resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience and not required to treat the resident's medical symptoms. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 10 residents (Resident #176) reviewed for baseline care plans.<br><br>The facility failed to ensure Resident #176's baseline care plan dated 10/21//2024 included instructions to address her present on admission diagnosis of PTSD-Post Traumatic Stress Disorder (a mental health condition that can develop after someone experiences or witnesses a traumatic event) within 48 hours of admission.<br><br>This failure could place the resident at risk of not receiving continuity of care and communication among nursing home staff, reduced resident safety, and reduced safeguards against adverse events that are most likely to occur right after admission.<br><br>Findings included:<br><br>Review of face sheet dated 11/13/2024 for Resident # 176 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of PTSD (a mental health condition that can develop after someone experiences or witnesses a traumatic event).<br><br>Review of Resident # 176's Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Resident # 176 had a diagnosis of PTSD checked under active diagnoses.<br><br>Review of Resident # 176's baseline care plan dated 10/21/2024 did not address the PTSD.<br><br>In an interview on 11/14/2024 at 1:40 PM with Resident # 176 reflected Resident # 176 stated no one from the facility had ever asked her about her PTSD and what her triggers are or what interventions she needed to maintain her mental health. Resident # 176 stated her PTSD was because she had been abused by males in the past. Resident # 176 stated she preferred female care staff because male care staff make her very uneasy due to her past. Resident # 176 also stated she preferred to be spoken to in the English language or have care staff that speak English as care staff speaking another language while providing care also makes her very uneasy.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 11/14/2024 at 2:15 PM the SW stated they were unsure if they needed to update a resident care plan when a resident has a diagnosis of PTSD as they had never had that diagnosis come up before. SW stated they were responsible for updating resident care plans regarding changed behaviors, advance directives, visual or auditory needs, dementia, cognition loss, and discharge needs. SW stated the initial assessment conducted with the resident was done by verbal communication with the resident and any information entered was only from what the resident verbally told her. SW stated that if a diagnosis of PTSD were on the resident list of diagnoses, then the resident should be asked about the diagnosis to see if any accommodations are needed to manage the residents care at the facility. SW stated they were unsure who was responsible for asking about accommodations pertaining to a PTSD diagnosis. SW stated if accommodation of needs are not updated on the care plan, then that could negatively affect the resident by the staff not knowing what the residents' could be.<br><br>In an interview on 11/14/2024 at 2:30 PM with SS reflected SS stated if a resident had a diagnosis of PTSD, then the resident baseline care plan and comprehensive care plan would be custom care plan's including their symptoms or triggers and the interventions needed to address those triggers. SS stated they are responsible for updating a resident's baseline and comprehensive care plan regarding behaviors and mental illness diagnoses. SS stated if a resident's care plan was not updated to address a resident with a diagnosis of PTSD, then it would depend on the resident symptoms or if the resident were asymptomatic as to whether it could negatively affect a resident.<br><br>In an interview on 11/14/2024 at 3:45 PM the DON stated their expectation was that resident care plans were updated accurately and timely. DON stated it was the responsibility of the SW to update baseline and comprehensive care plans regarding behaviors and mental illnesses including any resident triggers and interventions needed to manage their behaviors or illness. DON stated it could negatively affect a resident with a diagnosis of PTSD if their care plan was not updated to reflect that diagnosis in that the staff would not know the residents triggers.<br><br>In an interview on 11/14/2024 at 4:30 PM with the ADM reflected the ADM stated it was their expectation that resident care plans were complete and accurate. ADM stated it was the responsibility of the interdisciplinary team which included SW, SS, DDS, DON, ADON, Assistant ADM, and ADM to ensure resident care plan were complete and accurate. ADM stated if resident care plans were not completed or accurate then resident needs could not be met. ADM stated that for a resident with a diagnosis of PTSD if the care plan did not reflect that then the resident triggers could be missed.<br><br>Interview on 11/14/24 at 4;05PM, a request for the base line care plan policy was requested from ADM. Policy not provided prior to exit. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 9 residents (Residents #33, 151, and 176) reviewed for care plans.<br><br>The facility failed to ensure Resident # 33's care plan addressed her oxygen orders.<br><br>The facility failed to ensure Resident # 151's care plan addressed his dental needs and food allergies.<br><br>The facility failed to ensure Resident # 176's care plan addressed her present on admission diagnosis of PTSD-Post Traumatic Stress Disorder needs.<br><br>These failures could place residents at risk of not having their care and treatment needs met and a potential diminished quality of life.<br><br>Findings included:<br><br>Resident # 33<br><br>Review of face sheet dated 11/13/2024 for Resident # 33 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Cerebrovascular disease, anemia, foot drop right and left, schizoaffective disorder bipolar type, atrial fibrillation, anxiety disorder, bipolar disorder, atherosclerotic heart disease, vascular dementia, pain in right hip, dysphagia, cognitive communication deficit, pressure ulcer of sacral region stage 4, anxiety disorder, chronic pain, insomnia, hypertension, major depressive disorder, diaphragmatic hernia, and macular degeneration.<br><br>Review of Resident # 33 Quarterly MDS assessment dated [DATE] reflected a BIMS score of 3 indicating significant cognitive impairment. Resident # 33 no documentation under respiratory treatments oxygen therapy recorded.<br><br>Review of care plan for Resident # 33 dated 11/6/2024 reflected no documentation regarding oxygen use and care.<br><br>Review of clinical physician orders for Resident # 33 dated 11/27/2023 and revised on 3/4/2024 reflected oxygen saturation-check frequency every shift for hypoxia. Further review of physician orders dated 3/25/2024 reflected oxygen at 1-4 LPM via nasal cannula as needed for hypoxia. No documentation in orders to change or clean oxygen tubing or nasal cannula.<br><br>During an observation /interview on 11/13/2024 at 10:24 AM of Resident # 33 revealed Resident # 33 with oxygen nasal cannula in nostrils. Resident # 33 stated they must wear the oxygen all the time.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 11/14/2024 at 2:30 PM with MDSN revealed MDSN stated if a resident's oxygen order was on their comprehensive assessment or on their medication admission orders then the MDSN staff are responsible for updating the care plan if the resident receives a new order for oxygen after admission, then the responsibility for updating the care plan would be on the ADON or DON. MDSN stated if resident care plans are not accurate and complete then this could potentially negatively affect the resident by not receiving the care they need.<br><br>Resident # 151<br><br>Review of face sheet dated 11/13/2024 for Resident # 151 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of the bladder (bladder cancer), anemia, type 2 diabetes with foot ulcer, muscle wasting and atrophy, atrial fibrillation, hypertension, hyperlipidemia, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, acquired absence of other toes, abnormalities of gait and mobility, malaise, lack of coordination, and vitamin D deficiency. Listed under allergies it reads beets.<br><br>Review of Resident # 151 Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition.<br><br>Review of Resident # 151 care plan dated 05/22/2024 reflected no documentation regarding ADL's including dental care or any documentation of dental visits. Further review of care plan reflected no documentation regarding food allergies recorded.<br><br>Review of admission form dated 5/17/2024 reflected the resident checked that they requested a dental exam.<br><br>Record review of Resident #151's medical record from (5/7/2024) to (11/14/2024) revealed there was no record of dental an exam .<br><br>In an interview on 11/12/2024 at 2:56 PM with Resident # 151 revealed he has a food allergy to beets, and it was documented on his meal slip tickets but he keeps receiving meal trays with beets on them. Resident # 151 stated he missed his dental appointment to have castings done to receive a set of dentures. Resident # 151 stated he had made a dental appointment himself with the dentist. Resident # 151 stated he had let CST know of when the appointment was so it could be put in the transportation binder.<br><br>In an interview on 11/14/2024 at 12:05 PM the DDS stated the resident care plan should be updated for any food allergies. The DDS stated it was their responsibility to ensure that the dietary staff had been trained on food allergies and to update the resident care plan.<br><br>Resident # 176<br><br>Review of face sheet dated 11/13/2024 for Resident # 176 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis was PTSD (a mental health condition that can develop after someone experiences or witnesses a traumatic event),.<br><br>Review of Resident # 176's Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Resident # 176 had a diagnosis of PTSD checked under active diagnoses.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident # 176's care plan dated 10/22/2024 reflected no documentation regarding Resident # 176's diagnosis of PTSD.<br><br>In an interview on 11/14/2024 at 1:40 PM Resident # 176 stated no one from the facility had ever asked her about her PTSD and what her triggers are or what interventions she needed to maintain her mental health. Resident # 176 stated her PTSD was because she had been abused by males in the past. Resident # 176 stated she preferred female care staff because male care staff make her very uneasy due to her past. Resident # 176 also stated she preferred to be spoken to in the English language or have care staff that speak English as care staff speaking another language while providing care also makes her very uneasy.<br><br>In an interview on 11/14/2024 at 2:15 PM the SW stated they were unsure if they needed to update a resident care plan when a resident has a diagnosis of PTSD as they had never had that diagnosis come up before. SW stated they were responsible for updating resident care plans regarding changed behaviors, advance directives, visual, dental, or auditory needs, dementia, cognition loss, and discharge needs. SW stated the initial assessment conducted with the resident is done by verbal communication with the resident and any information entered is only from what the resident verbally tells the SW. SW stated that if a diagnosis of PTSD is on the resident list of diagnoses, then the resident should be asked about the diagnosis to see if any accommodations are needed to manage the residents care at the facility. SW stated they were unsure who was responsible for asking about accommodations pertaining to a PTSD diagnosis. SW stated if accommodation of needs is not updated on the care plan, then that could negatively affect the resident by the staff not knowing what the resident's triggers are.<br><br>In an interview on 11/14/2024 at 2:30 PM with SS revealed SS stated if a resident had a diagnosis of PTSD, then the resident care plan would be a custom care plan including their symptoms or triggers and the interventions needed to address those triggers. SS stated they are responsible for updating a resident's care plan regarding behaviors and mental illness diagnoses. SS stated if a resident's care plan was not updated to address a resident with a diagnosis of PTSD, then it would depend on the resident symptoms or if the resident were asymptomatic as to whether it could negatively affect a resident.<br><br>In an interview on 11/14/2024 at 3:45 PM the DON stated their expectation was that resident care plans were updated accurately and timely. DON stated it was the responsibility of the SW to update care plans regarding behaviors The DON stated it could negatively affect a resident if their care plan was not updated or by the resident potentially not receiving the services or care needed.<br><br>In an interview on 11/14/2024 at 4:30 PM with the ADM reflected the ADM stated it was their expectation that resident care plans were completed and accurate. The ADM stated it was the responsibility of the interdisciplinary team which included SW, SS, DDS, DON, ADON, Assistant ADM, and ADM to ensure resident care plan were completed and accurate. ADM stated if resident care plans were not completed or accurate then resident needs could not be met.<br><br>(continued on next page) |

| 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 11/14/2024 |
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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 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of comprehensive care plan policy dated 10/24/2022 reflected under heading policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under heading definitions: Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumata. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. Under heading policy explanation and compliance guidelines:<br><br>1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services<br><br>provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed.<br><br>2. The comprehensive care plan will be developed within 7 days after the completion of the<br><br>comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.<br><br>3. The comprehensive care plan will describe, at a minimum, the following:<br><br>a. The services that are to be furnished to attain or maintain the resident's highest practicable.<br><br>physical, mental, and psychosocial well-being.<br><br>g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. |

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| Heritage Park Rehabilitation and Skilled Nursing C | 2806 Real St<br>Austin, TX 78722 |

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001

50176

Based on observations, interview, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for four of ten residents (Resident #142, Resident #54, Resident #39 and Resident #60) reviewed for quality of life.

The facility failed to ensure Resident #142, Resident #54, Resident #39 and Resident #60 received regular showers.

These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life.

Findings included:

1. Review of Resident #142's Face Sheet reflected he was an [AGE] year-old male with an original admitted [DATE] and readmitted on [DATE] with diagnoses Unspecified viral hepatitis C (a viral infection that affects the live and can be life-threatening) without hepatic coma ( is a coma-like state that can occur due to liver failure), Schizophrenia ( is a chronic mental disorder that affects a person's ability to think, perceive reality, and interact socially) , Anemia due to enzyme disorder (is a type of hemolytic anemia that occurs when red blood cells break down faster than the body can replace them), Essential (primary) Hypertension (a type of high blood pressure that develops gradually over time and usually has no identifiable cause).

Review of Resident #142's MDS dated [DATE] reflected a BIMS score of 11 which indicates his cognition is moderately impaired. MDS indicated a #03 (section GG - I) rating for personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers and oral hygiene). #3 on MDS indicated Partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort.

Review of Resident #142's Care Plan dated 02/07/2023 reflected resident #142 is at risk for impaired skin integrity related to: anemia, impaired circulation, or sensation. The resident will remain free from alterations in skin integrity.

Record review of shower schedule revealed Resident #142 shower schedule was Tuesday, Thursday, and Saturday in the morning 6 a.m. to 2 p.m. shift.

Record review of Resident #142's shower log (dated 11/14/2024) for the past 30 days revealed the following:

*Resident not available had been marked on 11/12/2024.

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Resident refused had been marked on 10/26/2024, 10/31/2024, 11/02/2024, 11/05/2024 and 11/07/2024.<br><br>*Not applicable had been marked on 10/23/2024, 10/34/2024, 10/28/2024, 11/02/2024, 11/07/2024 and 11/09/2024.<br><br>During an interview and observation on 11/13/2024 at 1:17 p.m., Resident #142 stated he does not get his showers regularly. He stated that he asked staff yesterday (11/12/2024) for a shower and staff never took him one. He added that his shower day was tomorrow on 11/14/2024 and he hopes he gets one. Resident #60 was dressed in a hospital gown and his hair appeared oily and dirty. There were flies hovering over his blankets and gnats on his bedside table where he had clear drinks sitting.<br><br>During an interview and observation on 11/13/2024 at 04:02 p.m., Resident #142 was sitting in his room with a hospital gown on. Resident #60 stated he did not refuse his shower on 11/12/2024 and stated, he loves hygiene - I didn't refuse.<br><br>During an interview and observation on 11/14/2024 at 03:25 p.m., Resident #142 stated he had received his shower and he was a [NAME] for hygiene, and I like to be clean.<br><br>2. Review of Resident #54's Face Sheet reflected she was a [AGE] year-old female with an initial admitted [DATE] and readmitted on [DATE] with diagnoses of other cerebral vascular disease (a term for a range of conditions that impact blood flow and the blood vessels in the brain and spinal cord), Hyperlipidemia (a condition where there are abnormally high levels of lipids or fats in the blood)and diabetes (a chronic disease that occurs when the body can't produce or use insulin properly, resulting in high blood sugar levels).<br><br>Review of Resident #54's MDS dated [DATE] reflected a BIMS score of 15 which indicated she is cognitively intact. MDS indicated a #03 (section GG - I) rating for personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers and oral hygiene). #3 on MDS indicated Partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort.<br><br>Review of Resident #54's Care Plan dated 09/14/2023 reflected Resident #54 was at risk for impaired skin integrity related to: bladder incontinence, contractures, decreased subcutaneous tissue / lean muscle mass, diabetes with/or potential for fluctuating blood sugar level, hemiplegia/paresis, impaired circulation or sensation, impaired cognition, Impaired mobility. Resident will remain free from alterations in skin integrity.<br><br>Record review of shower schedule revealed Resident #54 shower schedule was Monday, Wednesday, and Saturday in the evening 2 p.m. to 10 p.m. shift.<br><br>Record review of Resident #54's shower log (dated 11/14/2024) for the past 30 days revealed the on the following:<br><br>*Resident refused had been marked on 11/16/2024.<br><br>*Not applicable had been marked on 10/23/2024, 10/34/2024, 10/28/2024, 11/02/2024 and 11/07/2024.<br><br>(continued on next page) |

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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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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and observation on 11/13/2024 at 11:58 a.m., Resident #54 stated she has not had a shower and there was a male on the second shift who refuses to give her a shower. Resident stated the staff flat out told her no because he was the only one. Resident has been proactive and has already informed the ADON. Resident #54 stated tonight is her shower night, so we'll see.<br><br>During an interview and observation on 11/14/2024 at 09:31 a.m., Resident #54 stated she received a shower last night. Resident voiced it was not the male that normally refuses it was a female staff member. Resident verbalized she never refuses her showers. Resident stated I am a clean person I am not incontinent. I never feel nasty, dirty because I change my clothes every day and I go pee on the toilet. I still feel clean it is not like I need my shower. I just like it.<br><br>3. Record review of Resident #39's Face Sheet dated, 11/14/2024, reflected a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with primary diagnoses of hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, other transient cerebral ischemic attacks and related syndromes, atherosclerosis of coronary artery bypass graft(s) without angina pectoris, essential primary hypertension and major depressive disorder.<br><br>Record review of Resident #39's Quarterly MDS Assessment, dated 10/22/2024, reflected Resident #39 had a BIMS score of 14 which indicate he is cognitively intact. MDS indicated a #03 (section GG - I) rating for personal hygiene. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers and oral hygiene). #3 on MDS indicated Partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort.<br><br>Record review of Resident #39's Comprehensive Care Plan, with a revision date of 02/12/2024, reflected Resident #39 has an ADL self-care performance. With a goal of: The resident will maintain current level of function with ads through the review date. Interventions included a revision on 02/04/2020 with the following: Bathing/Showering: The resident requires supervision to limited assist by 1 staff with (bathing/showering) 3x/week and as necessary and Provide sponge bath when a full bath or shower cannot be tolerated.<br><br>Record review filed grievance report dated 10/10/2024 filed by Resident #39 indicated that he was not getting showered on his shower days.<br><br>Record review of shower schedule revealed Resident #39 shower schedule was Monday, Wednesday, and Friday in the evening 2 p.m. to 10 p.m. shift.<br><br>Record review of Resident #39's shower log (dated 11/14/2024) indicated the following:<br><br>* Not applicable had been marked on 10/16/2024, 10/18/2024, 10/21/2024, 10/23/2024, 10/27/2024, 10/28/2024, 10/30/2024, 11/01/2024, 11/02/2024, 11/04/2024, 11/06/2024, 11/07/2024 11/08/2024 and 11/11/2024.<br><br>During an interview and observation on 11/14/2024 at 10:08 a.m., Resident #39 was non interviewable. Observed resident sitting in wheelchair in room watching TV. Would not answer questions.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Record review of Resident #60's face sheet dated 11/14/2024 revealed a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with primary diagnoses of schizoaffective disorder and (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), major depressive disorder (a mental disorder characterized by a persistently low or depressed mood and a loss of interest in normally enjoyable activities), and morbid obesity (a disease involving having too much body fat).<br><br>Record review of Resident #60's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating cognition intact. Resident #60 weighed 338 pounds, had frequent bowel incontinence, occasional urinary incontinence, and required supervision or touching assistance with shower/bathe task.<br><br>Record review of Resident #60's care plan dated 11/14/2024 revealed under ADL self-care resident required limited-extensive assistance with staff for bathing and showering three times per week and as necessary and to provide sponge bath when a full bath or shower could not be tolerated.<br><br>Record review of posted shower schedule in linen closet revealed Resident #60 shower schedule was Tuesday, Thursday, and Saturday in the evening 2 PM to 10 PM shift.<br><br>Record review of Resident #60's shower log (dated 11/14/2024) revealed Not applicable had been marked on 10/29/2024, 10/30/2024, 11/08/2024, 11/09/2024, 11/10/2024.<br><br>During an interview and observation on 11/12/2024 at 09:58 AM, Resident #60 stated he had not had a bath or shower in 10 days. He stated the facility did not have enough CNAs to give showers consistently. Resident #60 was dressed in a hospital gown and stated he wanted a shower, and his shower day was 11/12/2024.<br><br>During an interview and observation on 11/13/2024 at 05:05 PM, Resident #60 was sitting in the dining room dressed in hospital gown with no socks or shoes. Resident #60 stated he did not receive a shower on 11/12/2024 but did receive one on 11/13/2024 and he felt better. Resident #60 stated he had not moved to a different room, been out of the facility, or unavailable during his shower schedule, which was Tuesdays, Thursdays, and Saturdays. He was not on hospice and stated the CNAs were supposed to shower him. There had been a couple of times that he refused a shower because he was not feeling well. He had not received a sponge bath in lieu of a shower. Resident #60 stated he had not received his showers regularly and he believed it was because the facility did not have enough CNAs. Not getting his showers made him feel nasty and bad because he had bowel movements on himself and on the floor.<br><br>During an interview on 11/14/2024 at 08:47 a.m., CNA I stated that he gave residents showers on their shower days. CNA explained that residents have shower days scheduled every three days. If residents need frequent showers, then that is fine, but they usually have showers ordered for every three days. CNA explained that in the shower log, Not applicable meant maybe the resident is not there, they are out on leave, in the hospital or not available right now; So, cannot provide care, because resident is not there. When that occurred, the residents were asked when they returned if they wanted a shower. If they refused, the CNA voiced he would report that to the Charge Nurse.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/14/2024 at 09:01 a.m., CNA J stated that she gave residents showers on their shower days or whenever they ask for one. As my schedule permits it. I try to get the ones that scheduled that day and then I try to get the ones that asked for it. CNA explained that in the shower log, Not applicable meant they were not here for a shower. Or it is not their shower day, and they just have it wrong in PCC. Usually put NA when they are out on a pass. I wait until end of the shift to document. Cannot document at the beginning because they might come back. There is no way of changing the documentation or option for NA or Resident not available once I select that option. Unless, sometimes in PCC it says it is their shower day and it is not. Sometimes they get moved from another room and their shower day changed. But if they come back at any time of the day while I am here, they get their shower and sometimes they still get their shower on second shift. It depends on if they want it or not. CNA explained if a resident refuses their shower we let the nurse know. But we come back a few more times to ask them at least three times because sometimes they change their mind. We wait an hour or so and ask them. Try different approaches to see if that will make them want to take a shower. CNA verbalized it is important for resident to get regular showers for cleanliness; Good for their health if they have any sores, their skin and everything.<br><br>During an interview on 11/14/2024 at 09:15 AM, the RN A stated that the CNAs were to report to the charge nurse when the resident refused their scheduled showers. RNA A voiced that this is documented in the progress note by the RN. RNA A verbalized that if a resident is not in their room, the CNA is supposed to find them right away. RNA did not know why CNAs might mark Not applicable in the shower log. RNA A added that it is important for residents to shower regularly because it is good for their well-being.<br><br>During an interview on 11/14/2024 at 09:24 AM, CNA O stated that he gave residents showers. CNA explained that in the shower log, Not applicable meant either another agency, such as hospice, was responsible for giving showers; it was not a scheduled shower day (such as Sundays) or that residents were in line for a shower and staff ran out of time to give resident a shower. When that occurred, the resident's shower was delayed to the next shift or the next day.<br><br>During an interview on 11/14/2024 at 2:09 PM with DON. DON indicated that CNAs are responsible for taking residents showers. If a resident refuses a shower the CNA should continue to try to make them take a shower and if they still refuse they should try asking the resident the next day again. DON voiced it is important for residents to get regular showers so they can feel clean. Administrator was not asked about showers.<br><br>During an interview on 11/14/2024 at 3:51 PM with DON. DON verbalized that it is important for residents to get their showers regularly so they can feel clean and just be clean. DON verbalized a negative outcome for the resident if they do not get a regular shower could be that they would smell bad and the resident won't be clean. They will have body odor and it can make the resident feel very uncomfortable.<br><br>During an interview on 11/14/2024 at 09:45 AM, the ADON C stated that the shower log was posted in the linen closet and CNAs knew when their residents were supposed to receive showers. The ADON had heard residents complain about not getting showers regularly. CNAs might mark Not applicable if the resident moved rooms and the shower schedule needed to be updated.<br><br>Record review of the Facility's Policy on Activities of Daily Living (ADLs), implemented on 05/26/2023 reflected:<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Policy:<br><br>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.<br><br>Care and services will be provided for the following activities of daily living:<br><br>#1.<br><br>a.) Bathing, dressing, grooming and oral care.<br><br>b.) Deterioration of the resident's physical condition associated with the onset of an acute physical or mental disability while receiving care to restore or maintain functional abilities.<br><br>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.<br><br>#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. |

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|---|---|---|---|
| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001<br><br>50872<br><br>Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 3 of 16 residents (Residents #9, 58, and 130) reviewed for activities.<br><br>The facility failed to ensure Residents #9, 58, and 130 received activities according to their preference on their comprehensive assessments.<br><br>This failure placed residents at risk of boredom and diminished quality of life.<br><br>Findings include:<br><br>Resident #9<br><br>Review of Resident #9's face sheet revealed a [AGE] year-old male with admitted [DATE]. Diagnoses include Intellectual disabilities, kidney failure, Alzheimer's disease (a progressive disease that affects the memory and eventually the bodily functions), and seizures (an uncontrolled jerking cause by abnormal activity in the brain).<br><br>Review of Resident #9's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 0 reflecting severe cognitive impairment.<br><br>Review of Resident #9's Care Plan revealed Resident #9 has little involvement related to decreased cognitive and physical abilities. He was not verbal but will watch what was going on around him. He does like to attend most big events. The Goal revealed: Resident #9 will participate in sensory stimulation activities 1 to 2 times per week by review date. Resident #9 will participate in 1:1 in-room activities with staff 3 times per week until next review period. The interventions include Staff will escort resident to activity functions, The resident's past preferred activities appeared to be music, touch therapy and according to his family member he loved watching sports. Staff will interact with him during personal care. Staff will put the sports station on for him or play gospel music. Staff will do 1:1 with him 2-3 times a week.<br><br>Observation on 11/12/24 at 11:20 AM revealed Resident #9 sitting in wheelchair next to bed awake without any stimulation.<br><br>Observation on 11/12/24 at 2:47 PM revealed Resident #9 lying in bed awake looking at the ceiling. No stimulation in room.<br><br>Observation on 11/12/24 at 3:53 PM revealed Resident #9 was asleep in bed. No stimulation in room.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 11/13/24 at 9:42 AM revealed Resident #9 was sitting up in wheelchair next to the bed awake without any stimulation in the room.<br><br>Resident 58<br><br>Review of Resident 58's face sheet revealed an [AGE] year-old male with admitted [DATE]. Diagnosis includes schizoaffective disorder (a mental health condition that causes delusions, hallucinations, and fluctuating moods), vascular dementia (brain damage caused by multiple episodes of blood loss to the brain), and Cerebrovascular disease (a condition that affects the blood vessels to the brain).<br><br>Review of Resident #58's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 12 indicating mild cognitive impairment.<br><br>Review of Resident #58's Care Plan revealed Resident #58 prefers to stay in his room more often and has difficulty socializing due to cognitive deficit. The goals are Resident #58 will participate in at least one activity weekly through end of review. The interventions are given Resident #58 an activities calendar and staff will encourage Resident #58 to participate in activities. The care plan also stated the resident has no activity involvement related to disinterest, physical limitations and due to his recent decline in health. The goal is the resident will participate in 1:1 in-room individual activities with staff 2-3 times per week by review date. The interventions include Establish and record the resident's prior level of activity involvement and interest by talking with the resident, caregivers, and family on admission and as necessary, Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation, and Staff will visit resident 2-3 times per week for 1:1 in-room individual activities.<br><br>Observation on 11/12/24 at 11:21 AM revealed Resident #58 was in bed asleep.<br><br>Observation on 11/12/24 at 2:48 PM revealed Resident #58 was asleep in bed. No stimulation in room.<br><br>Observation on 11/12/24 at 3:54 PM revealed Resident #58 was awake in bed. No stimulation in room.<br><br>Observation on 11/13/24 at 9:43 AM revealed Resident #58 was asleep in bed. No stimulation noted in the room.<br><br>Observation and interview on 11/13/24 at 1:38 PM revealed Resident #58 was awake in bed. When asked about if he liked the TV. Resident stated the TVs in the room were not his. He also stated he preferred to stay in his room.<br><br>Resident #58 kept repeating his family comes to visit him and brings him gifts. Resident's speech was difficult to understand, and no further conversation was understood.<br><br>Resident #130<br><br>Review of Resident #130's face sheet revealed an [AGE] year-old male with admitted [DATE]. Diagnosis include dementia (difficulty with memory and thought processes), neoplasm of prostate (cancer), diabetes mellitus (difficulty in regulation of blood sugar levels), and contracture of left elbow(inability to move left elbow).<br><br>(continued on next page) |

| 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 11/14/2024 |
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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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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #130's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score was not completed due to short- and long-term memory issues.<br><br>Review of Resident #130's Care Plan revealed Resident #130 is not involved in activities due to a decline in health and now being on hospice. The goal stated Resident #130 wishes regarding activities will be honored through review. The interventions stated Offer Resident #130 one on one activities in his room.<br><br>Observation on 11/12/24 at 10:51 AM revealed Resident # 130 asleep in bed. No stimulation in room.<br><br>Observation on 11/12/24 at 2:30 PM revealed Resident # 130 asleep in bed. No stimulation in room.<br><br>Observation on 11/13/24 at 9:19 AM revealed Resident # 130 asleep in bed. No stimulation in room.<br><br>Interview on 11/14/24 at 10:53 PM the AD revealed he had obtained the position as activity director 2 weeks ago. He stated he has been catching up because the facility has not had an activities director in a while. The AD stated he is still in the process of introducing himself to all residents. He stated he has a list of bed bound residents and those residents who prefer activities in room. The AD stated the goal was to provide 1:1 activity in their room [ROOM NUMBER]-5 times per week. The AD stated he had stopped by the room for Resident #9 that morning and was going to take Resident #9 to activities, but a CNA stopped him and stated they were fixing to change Resident #9 first. Denied following up afterward. The AD stated he wants all the activity aides to work together to take care of all the resident's and not have assigned staff to each resident. He also stated Resident # 58 was not in his room this morning, but in the past the AD has worked with Resident #58. He stated Resident #58 gets the daily chronicles and staff was encouraged to bring all residents to activities. The AD stated that lack of person-centered activities for the residents could cause depression. The AD stated he expected documentation for the activities but was unable to provide documentation for the activities for Resident's #9, 58, and 130.<br><br>Interview on 11/14/24 at 3:48 PM with the DON revealed her expectations for residents that are bed bound are to have an in-room activity. She stated activities should have a plan and visit a few times a day and be reading or provide the radio to those residents in their rooms. The DON explained that her expectation would be all activities are to be documented each time. She stated residents could become bored and withdrawn if no activities are provided to those resident's that are in their room all the time.<br><br>Interview on 11/14/24 at 4:39 PM with the ADM revealed his expectations for residents that are bed bound are that residents should be provided activities in accordance with the standard. He stated all the activities should be care planned and all residents should have some type of activity daily. The ADM state without activities it could affect their quality of life.<br><br>Record review of the list of bedbound residents and those residents who prefer in room activities dated 11/1/24 revealed Residents # 9 and 58 on list.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Activity Policy dated 9/14 revealed a policy statement: The facility has an on-going program of activities designed to meet the interests and the physical, mental, spiritual, and psychosocial well-being of each resident in accordance with his/her comprehensive assessment. The Policy Interpretation and Implementation stated the purpose: The facility will provide activities that are designed to appeal to the residents' interests and enhance their highest practicable level of physical, mental, spiritual, and psychosocial well-being. In Room Activities: All residents, particularly bedfast and those residents unable to participate in group activities will be visited by Activity Director, Activity Assistant, and/or volunteers at least 3 times a week. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872<br><br>Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident and hazards as possible for 1 of 3 residents reviewed for accidents and hazards (Resident #13).<br><br>The facility failed to ensure soap was secured in labeled container in Resident #13's room.<br><br>This failure could result in residents experiencing accidents and possible illness, injury, and hospitalization by inadvertently consuming unknown substances.<br><br>Findings included:<br><br>Review of Resident #13's face sheet revealed an 80-years-old male with admitted [DATE] with a discharge date of [DATE]. Diagnosis included: vascular dementia (memory and thought process difficulties related to multiple strokes, or loss of blood circulation to the brain), dysphagia (difficulty swallowing), and cognitive communication deficit (inability to communicate).<br><br>Review of Resident #13's initial minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 12 which indicated mild cognitive impairment. Review of Resident #13's Care Plan dated 9/9/2024 and revised on 11/12/2024 revealed, Resident #13 has a swallowing problem related to Cerebrovascular Accident (sudden interrupted blood supply to the brain). Resident #13 has potential nutritional problem relate to Mechanical Soft Diet with Nectar Thick Liquid.<br><br>Record review of Resident #13's Nursing progress notes dated 8/31/2024 at 1:10 PM revealed Called to the room by FM because Resident #13 was coughing after drinking something. She showed me a small cup and asked what it was. I asked where she got it from, stated on side of TV FM mistakenly gave him one drank of shower gel. Vs 120/55 18 97.4 95 sat . No vomiting notice or adverse reactions. Elevated head of bed for cough. Notified NP on call resident to be monitor.<br><br>Record review of Resident #13's Nursing progress notes dated 8/31/2024 at 2:45 revealed Late Entry: charge Nurse was called to the room by FM because Resident #13 was coughing after drinking something. She showed the nurse a small cup and asked what it was and told her that she got it from behind the TV thinking it was a Jello. She also told the nurse that she mistakenly gave him one drank of shower gel, resident spit it. Vs 120/55 18 97.4 95 sat. No vomiting notice or adverse reactions. Elevated head of bed for cough. Notified NP on call resident to be monitor.<br><br>Record review of incident reports from 8/31/24 at 1:29 PM revealed Resident FM gave resident mistakenly a small sip of shower gel which she stated that she picked it from the side of the TV because she though it was Jello. She also stated that as soon as it touches his mouth, he starts spitting it and coughing it out. Resident was assessed, no injuries noted, no nausea or vomiting. Resident unable to give a description other info a cup of shower get was placed behind TV.<br><br>(continued on next page) |

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|---|---|---|---|
| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 11/14/24 at 11:16 AM with FM of Resident #13, she stated that an incident happened on 8/31/24 where she mistakenly gave Resident #13 a drink of soap from an unlabeled cup in his room that was sitting next to the TV. She stated the liquid appeared to be about the consistency of the liquid he was ordered, and she thought it was for him to drink. FM expressed concern for the inadequacy of care provided after the incident happened.<br><br>During interview on 11/14/24 at 3:14 PM with LVN G stated the FM had called her into the room because she had given him something from a cup in the room. When LVN G went to the room and did an assessment the FM showed her a cup and ask if LVN G had given the FM something. LVN G stated she had given the FM water from the kitchen and asked the FM where she got the cup of red liquid from. FM stated she had found it next to the TV. LVN G then assessed the cup by smelling it and poured some of it into the sink to assess the consistency of the liquid. LVN G then added water to the sink and noticed the liquid was soap of some type. LVN G stated the consistency of the soap was almost the same consistency of the resident's thickened liquid. LVN G stated the FM thought the cup of liquid was jello. LVN G stated she documented everything in the nurses note and called the on-call doctor. On call doctor told LVN G to monitor the resident and call back if any changes in status occur. LVN G stated the soap should not have been in a cup, but she does not know who brought it into the room and put it next to the TV. She stated she did not notice the cup of liquid earlier in the day, but she did not look at the side of the TV either. She stated she was not sure if it could be harmful to the resident if ingested. LVN G stated there were no ill effects from the incident. Resident #13 consumed 100% of his dinner that night.<br><br>During interview on 11/14/24 at 3:48 PM with the DON, she stated the FM had requested and been provided a cup of thickened water for the resident. She stated that the FM then saw a cup of red liquid from behind the TV and proceeded to give Resident #13 a drink of the red liquid. The DON stated that Resident #13 immediately spit the liquid out. She stated that LVN G assessed Resident #13 and LVN G stated the resident did not swallow any of the red liquid and no harm was done. The DON also stated that her investigation did not reveal how the soap got in a cup and on the dresser by the TV. The DON stated the only soap in the facility at that time was green in color and the soap in the bathroom was clear. The DON stated she does not know how swallowing soap could affect a resident.<br><br>During interview on 11/14/24 at 4:39 PM with the ADM, he stated he was notified about the incident with a resident possibly ingesting a substance that a family member thought was some kind of drink but was actually soap. He stated the family member found it on the dresser by the TV. He stated the FM attempted to give Resident #13 a drink and the resident immediately spit it out. The ADM stated after an inhouse investigation it was not determined when or how the soap ended up in a cup on the resident's dresser, but we have in serviced all staff and have changed some procedures since then.<br><br>Record review of Inservice dated 10/17/24, topic What to do in case of ingestion of substance other than food revealed a summary of session Find out what is the substance is? Assessment of the resident. Call poison control center 1 800 222 1222 and get directions on how to proceed. MD, RP, DON, and Administrator notification. Start an Incident report for Ingestion.<br><br>Record review of the facilities policy titled Incidents and Accidents dated 8/15/22 reflected the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.<br><br>Definitions:<br><br>Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.<br><br>An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member.<br><br>Policy Explanation: The purpose of incident reporting can include:<br><br>-Assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care.<br><br>-Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences.<br><br>-Alert administration of occurrences that could result in reporting requirements.<br><br>-Meeting regulatory requirements for analysis and reporting of incidents and accidents.<br><br>Compliance Guidelines:<br><br>1. Incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information.<br><br>2. Licensed staff will utilize PCC Risk Management to report incidents/accidents and assist with completion of any investigative information to identify root causes.<br><br>3. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed, and reported according to the facility's abuse prevention policy.<br><br>4. The following incidents/accidents require an incident/accident report but are not limited to: Alleged abuse, Choking, Combative behavior, Drug diversion, Elopement, Entrapment, Equipment malfunction, Falls, Medication or treatment errors, Observed accidents/incidents, Pressure injuries/ulcers, Resident to resident altercations, Resident injuries due to staff handling, Self-inflicted injuries, Suicide or attempted suicide, Unexpected deaths, Unobserved injuries.<br><br>5. In the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm.<br><br>6. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions.<br><br>(continued on next page) |

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| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 7. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events.<br><br>8. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies).<br><br>9. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner.<br><br>10. The resident's family or representative will be notified of the incident/accident and any orders obtained of if the resident is to be transported to the hospital.<br><br>11. The nurse will enter the incident/accident information into the appropriate form/system within 8 hours of occurrence and will document all pertinent information.<br><br>12. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions.<br><br>13. The nurse will examine and render any first aid to any visitor or employee involved in an incident/accident and will assist with arranging transportation to the hospital, if warranted.<br><br>14. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on interviews and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounted for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization for 1 (Resident #176) of 3 resident reviewed for quality of care.<br><br>The facility failed to ensure that Resident #176's potential triggers were care planned.<br><br>This failure could place residents at increased risk for psychological distress due to re-traumatization.<br><br>Findings included:<br><br>Review of face sheet dated 11/13/2024 for Resident # 176 reflected a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis of PTSD (a mental health condition that can develop after someone experiences or witnesses a traumatic event)<br><br>Review of Resident # 176's Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Resident # 176 had a diagnosis of PTSD checked under active diagnoses. Resident # 176's mood section of the MDS reflected resident had felt down, depressed, or hopeless with a frequency of half or more of the days. Resident # 176 mood section also reflected resident had felt bad about themselves or that they were a failure or had let themselves down half or more of the days. No behaviors recorded for Resident # 176.<br><br>Review of Resident # 176's baseline care plan dated 10/21/2024 reflected under section mood and psychosocial wellbeing no documentation of PTSD diagnosis recorded. No interventions in place to address or mitigate Resident # 176's diagnosis of PTSD recorded.<br><br>Review of Resident # 176's care plan dated 10/22/2024 reflected no documentation regarding Resident # 176's diagnosis of PTSD.<br><br>In an interview on 11/14/2024 at 1:40 PM Resident # 176 stated no one from the facility had ever asked her about her PTSD and what her triggers are or what interventions she needed to maintain her mental health. Resident # 176 stated her PTSD was because she had been abused by males in the past. Resident # 176 stated she preferred female care staff because male care staff make her very uneasy due to her past. Resident # 176 also stated she preferred to be spoken to in the English language or have care staff that speak English as care staff speaking another language while providing care also makes her very uneasy.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 11/14/2024 at 2:15 PM the SW stated they were unsure if they needed to update a resident care plan when a resident has a diagnosis of PTSD as they had never had that diagnosis come up before. SW stated the initial assessment conducted with the resident was done by verbal communication with the resident and any information entered was only from what the resident told the SW. SW stated that if a diagnosis of PTSD was on the resident list of diagnoses, then the resident should be asked about the diagnosis to see if any accommodations are needed to manage the residents care at the facility. SW stated they were unsure who was responsible for asking about accommodations pertaining to a PTSD diagnosis. SW stated if accommodation of needs was not updated on the care plan, then that could negatively affect the resident by the staff not knowing what the resident's triggers are.<br><br>In an interview on 11/14/2024 at 2:30 PM SS stated if a resident had a diagnosis of PTSD, then the resident care plan would be a custom care plan including their symptoms or triggers and the interventions needed to address those triggers. SS stated they are responsible for updating a resident's care plan regarding behaviors and mental illness diagnoses. SS stated if a resident's care plan was not updated to address a resident with a diagnosis of PTSD, then it would depend on the resident symptoms or if the resident were asymptomatic as to whether it could negatively affect a resident.<br><br>In an interview on 11/14/2024 at 3:45 PM the DON stated their expectation was that resident care plans were updated accurately and timely. DON stated it was the responsibility of the SW to update care plans regarding behaviors. DON stated it could negatively affect a resident with a diagnosis of PTSD if their care plan was not updated to reflect that diagnosis in that the staff would not know the residents' triggers.<br><br>In an interview on 11/14/2024 at 4:30 PM the ADM stated it was their expectation that resident care plans were completed and accurate. ADM stated it was the responsibility of the interdisciplinary team which included SW, SS, DDS, DON, ADON, Assistant ADM, and ADM to ensure resident care plan were completed and accurate. ADM stated if resident care plans were not completed or accurate then resident needs could not be met. ADM stated that for a resident with a diagnosis of PTSD if the care plan did not reflect that then the resident triggers could be missed.<br><br>Interview on 11/14/24 at 4:05 PM of the ADM was asked for the facility's base line care plan policy ,policy not provided prior to exit.<br><br>Review of comprehensive care plan policy dated 10/24/2022 reflected under heading policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under heading definitions: Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumata. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. Under heading policy explanation and compliance guidelines:<br><br>1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care. Services<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed.<br><br>2. The comprehensive care plan will be developed within 7 days after the completion of the<br><br>comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.<br><br>3. The comprehensive care plan will describe, at a minimum, the following:<br><br>a. The services that are to be furnished to attain or maintain the resident's highest practicable.<br><br>physical, mental, and psychosocial well-being .<br><br>g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. |

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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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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>50001<br><br>Based on observations, interviews, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 7.69 % based on 2 errors out of 26 opportunities, which involved 2 of 4 residents (Resident #1 & #156) and 2 of 2 staff (MA R and MA T) reviewed for medication errors, in that:<br><br>MA R administered a whole Metroprolol ER (Extended release or slow release) gel pill and the Resident #1 had orders to crush all medications.<br><br>MA T administered 1 medication (Metroprolol) which was ordered to be given if blood pressure reading was within the parameters. Orders indicated to hold (do not give to resident) if blood pressure reading is outside of the parameters. The blood pressure was outside of the parameters.<br><br>These failures could place residents at risk of medication errors that could cause a decline in health.<br><br>Findings included:<br><br>During an observation on 11/12/2024 at 03:29 p.m., MA R was observed passing medications to Resident #1 which included 5 medications (Dicyclomine 10MG, Acidophilus Probiotic, Fish Oil 1000 MG (gel capsule), Quetiapine Fumarate 100 MG and Dorzolamide). Resident #1 had orders for all medications to be crushed. MA R crushed all medications except the Fish Oil 1000 MG (gel capsule). MA R administered the Fish Oil as a whole gel pill along with the crushed medications.<br><br>During an interview with MA R on 11/12/24 03:38 p.m., MA R voiced that she did not cut the fish oil pill because the resident takes it whole and if she cuts it, he will not get all the medication. MA R verbalized it's a gel you can't crush it. When asked the MA R what the facility policy is for gel pills with orders to crush, she verbalized she doesn't know the policy to be honest. She just goes based off of her experience with the resident.<br><br>During an interview on 11/14/2024 at 08:25 a.m. MA T stated she knew when medications are supposed to be crushed because it was in the computer under the resident's orders. MA T stated gel medications should not be crushed. MA T added that you cannot crush the gel medication and you just go back to the nurse, and they will see what is going on. MA T stated if a resident gets a medication that is supposed to be crushed, they can choke, and it can kill the resident. MA T added You can't give a resident a pill if you are supposed to crush it because it means he can't swallow it.<br><br>During an interview on 11/14/2024 at 2:09 p.m., the DON stated gel medications are not to be crushed. DON added I think they need to notify the nurse and let them know this resident has crushed medications and get them to change the order or get another alternative to crush . The DON stated if a resident was supposed to get a crushed medication and they get a whole one instead, they can choke on it, and they will not be able to swallow it. The DON voiced the last time staff were in-serviced on medication administration was with the month or 2 months and the ADON was responsible for providing the in-services to staff.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 11/13/2024 at 07:13 a.m., MA T was observed obtaining Resident #156 blood pressure and it was: 145/67 with a HR of 54. MA T was observed passing medication to Resident # 156 which included the following medication (Metoprolol Succinate ER (Extended release or slow release) Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to Essential (primary) Hypertension (110) Hold for SBP <110 or HR <60)<br><br>Record review on 11/12/2024 of Resident #156's clinical physician orders revealed: Metoprolol Succinate ER (Extended release or slow release) Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to Essential (primary) Hypertension (110) Hold for SBP <110 or HR <60.<br><br>Record Review on 11/14/2024 of the Medication Administration Policy with implementation date of 10/24/2022 Policy: Medications are administered by licensed nurses, or staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.<br><br>Explanation and Compliance Guidelines:<br><br>#8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.<br><br>#14 Administer medication as ordered in accordance with manufacturer specifications.<br><br>C. Crush medications as ordered. Do not crush medication with do not crush instructions.<br><br>Example guidelines for Medication Administration (unless otherwise ordered by physician), this list is not all-inclusive.<br><br>Do Not Crush Medications:<br><br>Slow release<br><br>Enteric coated |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001<br><br>Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 (Resident#156) of 4 resident reviewed for pharmaceutical services.<br><br>The facility failed to follow prescriber's orders and professional standards and principles which apply to professionals providing services for Resident #156's scheduled medications. MA T administered 1 medication (Metroprolol) which was ordered to be given if blood pressure reading was within the parameters. Orders indicated to hold (do not give to resident) if blood pressure reading is outside of the parameters. The blood pressure was outside of the parameters.<br><br>This failure could place residents at risk of discomfort or jeopardizes his or her health and safety.<br><br>Findings included:<br><br>Record Review on 11/14/2024 of Resident #156's face sheet reflected Resident #156 was a [AGE] year-old male with an original admitted [DATE] and admitted [DATE]. Resident #156 had a diagnoses of Essential (primary) Hypertension (is a common condition that affects the body's arteries) .<br><br>Record Review on 11/14/2024 of the most recent MDS assessment dated [DATE] reflected Resident #156 had a BIMS score of 6 indicating Resident #156 was severely cognitively impaired.<br><br>Record review on 11/12/2024 of Resident #156's clinical physician orders revealed: Metoprolol Succinate ER (Extended release or slow release) Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to Essential (primary) Hypertension (110) Hold for SBP <110 or HR <60.<br><br>During an observation on 11/13/2024 at 07:13 a.m., MA T was observed obtaining Resident #156 blood pressure and it was: 145/67 with a HR of 54. MA T administered 1 tablet of Metoprolol Succinate ER (Extended release or slow release) .<br><br>In an interview on 11/14/2024 at 08:25 a.m., MA T stated she was not supposed to give a resident a blood pressure medication if it was outside of the parameters for giving. MA T stated if the resident was given a blood pressure medication when their blood pressure was out of the parameters it can harm the resident and MA T voiced, she was supposed to follow the orders in the MAR in the PCC system. MA T verbalized the staff get in-serviced every week on the proper administration process.<br><br>Record Review on 11/14/2024 of the Medication Administration Policy with implementation date of 10/24/2022 Policy: Medications are administered by licensed nurses, or staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.<br><br>Explanation and Compliance Guidelines:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50001<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 2 of 4 medication carts reviewed in that:<br><br>The medication cart for the 2400 hall and one cart by the front entrance on the lower level were not locked.<br><br>During a medication review, MA T walked away and left the medications out with the surveyor, instead of locking the medications back up.<br><br>These deficient practices could affect residents and result in a drug diversion due to medications not being properly disposed and secured.<br><br>The findings were:<br><br>Observation on 11/13/2024 at 7:13 a.m., of the medication cart for the 2400 was not locked when MA T, was administering medications.<br><br>Observation on 11/13/2024 at 7:40 a.m., MA T, walked away from cart and left medications with the surveyor, during a medication pass inspection. The medications were not in sight of MA T view. MA T walked down the hall to ask the charge nurse for clarification on a medication order.<br><br>Observation on 11/13/2024 at 7:49 a.m., MA T returned to cart with the ADON . MA T was instructed by the ADON to act as if the surveyor is not here and reminded that she is to lock up medications when she is walking away from her cart. At 7:56 am MA T, stated she would not leave the medications out because people can come up and take them. MA T stated she has never done that before, she just assumed the surveyor would watch the medications and the medications were okay.<br><br>Observation on 11/13/2024 at 5:49 p.m., revealed an unlocked medication cart by the front entrance on the first floor. There were no staff nearby the cart and residents were in the area.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with MA T on 11/13/2024 at 8:07 a.m., MA T, reported she would never leave the medications out, she stated she put everything inside and locked the cart and then she would have walked away. MA T voiced someone could take the medications, if she left them out and it could be a medication like a blood pressure medication and if a resident takes it and they are not supposed to, maybe someone can die. MA T voiced the facility told staff every time they have to lock their carts with the medications in them and then go, even if someone is dying, even if there is a fire, lock the medications in the cart and do not leave them out. MA T voiced she left them out today with the surveyor because the surveyor was there, and she thought it was okay to leave the medications with the surveyor, but she knew the rules. MA T voiced she did not lock the medication cart when she was giving a resident medication because she was in the room and the cart was pushed up against the door so, no one can get the cart. MA T voiced I must lock it but maybe I fear you and forgot. I do not know; I am supposed to calm down. She voiced I have to lock my cart. MA T sated if she does not lock her cart, maybe someone can come and pull it, maybe somebody fall, maybe he can take my things medications here. MA T voiced the policy for locking the medication cart indicates they have to lock the cart.<br><br>Interview with DON on 11/14/2024 at 2:09 p.m., stated staff are supposed to lock their carts when they walk away from them. The DON voiced if a staff member does not lock their medication cart, somebody can get in their cart. This can harm a resident.<br><br>Record review revealed an in-service for Medication Storage (please make sure medication cart is close when not in use. Do not let medication cart opened and unattended) signed by staff on 07/17/2024.<br><br>Review of the medication administration policy on 11/14/2024 implemented on 10/24/2022 did not include medication storage or mention locking medication carts. |

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| F 0778<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Help the resident make transportation arrangements to and from radiology services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on interviews and record review the facility failed to provide diagnostic services to meet the needs of its residents in a timely manner for 1 of 9 (Resident # 153) residents reviewed for radiology services.<br><br>The facility failed to ensure Resident # 153 was taken to their imaging appointment in a timely manner to ensure their appointment was not canceled due to being late for the appointment.<br><br>This failure could place residents at risk of delayed diagnosis and medical treatment to prevent complications and injuries.<br><br>Findings included:<br><br>Resident # 153<br><br>Review of face sheet dated 11/13/2024 for Resident # 153 reflected a [AGE] year-old female admitted to the facility on [DATE].<br><br>Her diagnoses included schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly), epilepsy (a seizure disorder), pain in right hip, altered mental status, chronic pain, depression, insomnia, , and pelvis fracture.<br><br>Review of Quarterly MDS assessment dated [DATE] for Resident # 153 reflected a BIMS score of 10 which indicated moderate cognitive impairment. Resident # 153 had impairment on one side of their lower extremities (hip, knee, ankle, foot).<br><br>Review of Resident # 153 care plan dated 6/20/2024 reflected resident has chronic pain related to right hip pain. Interventions include monitor/document for side effects of pain medication. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment.<br><br>Review of Resident # 153 Clinical Physician orders reflected a order for pain monitoring by nursing staff every shift dated 3/11/24, an order for acetaminophen 500 mg dated 3/11/24, and a order for acetaminophen-codeine 300-30 mg dated 5/20/24. Order to obtain follow up with ortho for chronic right hip pain dated 7/17/24. No orders for imaging appointment reschedule documented.<br><br>In an interview on 11/13/24 at 10:44 AM Resident # 153 stated they were taken to an MRI imaging appointment last week and they arrived at the appointment late, so the appointment had been canceled. Resident # 153 stated they were frustrated with the fact that the facility van driver had not left the facility in time to get them to the appointment on time and their appointment was canceled. Resident # 153 stated I have continued pelvic pain and I really needed to go to that appointment. Resident # 153 stated they are unsure if the appointment has been rescheduled or who will be taking them to future appointments as the facility van driver told them that they would no longer be working for the facility. Resident # 153 stated nobody from the facility has communicated with me about any of my future appointments.<br><br>(continued on next page) |

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| F 0778<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 11/14/24 at 10:00 AM the CST stated the process for resident transportation to appointments was the facility makes appointments for residents then the appointment was put into the scheduler appointment book. The CST stated if the resident makes the appointment for themselves then the resident must notify the CST or the nurse who will notify the CST so the appointment can be put into the scheduler appointment book. The CST stated Resident # 153 had an imaging appointment that had been canceled due to the facility not getting the resident to the appointment on time. The CST stated the facility van had been in the shop and the van driver was unaware that the facility had secured a van from a sister facility to transport residents to appointments. The CST stated when the van driver realized the facility had secured a vehicle the driver took Resident # 153 to the imaging appointment but was late to the appointment and the imaging facility therefore canceled the appointment. The CST stated it was their and the driver's responsibility to ensure resident transportation to appointments was secured and carried out. CST stated if residents missed scheduled appointments this could negatively affect the residents by the resident becoming upset or possibly taking a long time to reschedule their medical appointments. CST stated after looking in appointment scheduling book that an appointment had been rescheduled for Resident # 153 on 11/18/24. CST was unsure if facility staff had communicated with the resident about the rescheduled appointment. CST was also unsure if the NP/MD had been notified of the missed appointment.<br><br>Attempted interview on 11/14/24 at 10:15 AM of facility van driver however interview not conducted as van driver is no longer employed by facility.<br><br>In an interview on 11/14/24 at 4:30 PM the ADM stated their expectation concerning resident transportation was the residents would be transported to their appointments as scheduled. The ADM stated it was the responsibility of the interdisciplinary team including the transportation coordinator, driver, nurse, and social worker to ensure the residents receive the treatments required and are taken to their scheduled appointments. The ADM stated this failure could negatively affect residents by potentially missing appointments or having to reschedule and have a negative health outcome.<br><br>Interview on 11/13/24 at 5:33PM, the ADM stated the facility does not have a transportation policy. |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on interviews and record review the facility failed to assist residents in arranging transportation to and from dental services location to meet the needs of 1 of 6 (Resident # 151) reviewed for dental services.<br><br>The facility failed to assist Resident # 151 with arranging transportation to and from dental services location to complete his dental appointment for castings to be made for dentures.<br><br>This deficient practice could affect residents by placing them at risk of not receiving dental care.<br><br>Findings included:<br><br>Review of face sheet dated 11/13/2024 for Resident # 151 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of the bladder (bladder cancer), muscle wasting and atrophy, malaise, , and vitamin D deficiency.<br><br>Review of the Quarterly MDS assessment dated [DATE] for Resident # 151 reflected a BIMS score of 15 indicating intact cognition. MDS oral/dental status section did not have any documentation recorded.<br><br>Review of Resident # 151's care plan dated 05/22/2024 reflected no documentation regarding ADL's including dental care or any documentation of dental visits.<br><br>Review of forms to be completed upon admitted d 5/17/2024 reflected the resident checked that they requested a dental exam.<br><br>Record review of Resident #151's medical record from (5/7/2024) to (11/14/2024) revealed there was no record of a dental exam.<br><br>In an interview on 11/12/2024 at 2:56 PM Resident # 151 stated he missed his dental appointment to have castings done to receive a set of dentures. Resident # 151 stated he had made a dental appointment himself with the dentist. Resident # 151 stated he had let CST know of when the appointment was so it could be put in the transportation binder. Resident # 151 stated he was told by CST that the facility van was in the shop and that they would provide a public transportation pass for him to attend the appointment. Resident #151 stated he attempted to take public transportation to the appointment but that was unsuccessful as the public transportation service did not go all the way out to where his dentist office was located. Resident # 151 told the CST that public transportation did not cover the area where his dentist office was located but by that time, he had missed his appointment. Resident # 151 stated he had concerns because he really needed to see the dentist and he was unsure if the facility transportation were unavailable how he would get to his appointment.<br><br>(continued on next page) |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 11/14/24 at 10:00 AM the CST stated if the resident made an appointment for themselves then the resident must notify the CST or the nurse who will notify the CST so the appointment can be put into the scheduler appointment book. The CST stated Resident # 151 had a dental appointment that had been missed due to the facility transportation being in the shop and public transportation not being available due to coverage area. The CST stated the facility van had been in the shop and the CST had given Resident # 151 a public transportation pass but was unaware that the public transportation coverage area did not include the town where Resident# 151 dentist was located. The CST stated it was their responsibility to ensure resident transportation to appointments was secured and carried out. CST stated if residents missed scheduled appointments this could negatively affect the residents by the resident becoming upset or possibly taking a long time to reschedule their medical appointments.<br><br>In an interview on 11/14/24 at 4:30 PM with the ADM revealed ADM stated their expectation concerning resident transportation was the residents would be transported to their appointments as scheduled. The ADM stated it was the responsibility of the interdisciplinary team including the transportation coordinator, driver, nurse, and social worker to ensure the residents receive the treatments required and are taken to their scheduled appointments. The ADM stated this failure could negatively affect residents by potentially missing appointments or having to reschedule and have a negative health outcome.<br><br>Interview on 11/13/24 at 5:35PM the ADM stated the facility does not have a transportation policy.<br><br>Review of Resident Rights posting dated 11/2021 reflected Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on observation, interviews and record reviews, the facility failed to provide food that accommodates residents' allergies, intolerances, and preferences for one (1) of ten (10) residents (Resident # 151) reviewed for food allergies.<br><br>The facility kitchen failed to honor Resident # 151 food allergies according to his meal ticket and served him beets which his meal ticket stated he had an allergy to.<br><br>This failure placed the resident at risk of consuming a food allergen.<br><br>Findings included:<br><br>Review of face sheet dated 11/13/2024 for Resident # 151 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anemia, type 2 diabetes with foot ulcer, and vitamin D deficiency. Listed under allergies it reads beets.<br><br>Review of the Quarterly MDS assessment dated [DATE] for Resident # 151 reflected a BIMS score of 15 indicating intact cognition.<br><br>Review of the care plan for Resident # 151 dated 05/22/2024 reflected the following resident was on an RCS (Reduced Concentrated Sweets) diet related to diagnosis of diabetes type 2. Interventions of provide, serve diet as ordered. Monitor intake and record for each meal. No documentation of a food allergy recorded.<br><br>Review of meal ticket slip for Resident # 151 dated 11/15/2024 reflected Resident # 151 on a regular texture Reduced Concentrated Sweets diet with an allergy listing of Beets.<br><br>Observation on 11/12/2024 at 12:00 PM of downstairs dining room meal service revealed nursing performing proper hand hygiene, checking resident meal trays, and resident meal tray set up assistance. No discrepancies, patterns, or trends identified.<br><br>In an interview on 11/12/2024 at 2:56 PM with Resident # 151 revealed Resident # 151 stated he has a food allergy to beets, and it was documented on his meal slip tickets but he keeps receiving meal trays with beets on them. Resident # 151 stated when he received a tray with beets, he just sends it back and requests a new tray and reminds staff of his food allergy. Resident # 151 stated he never eats any of the food from the tray with the beets as the juice gets all over the other food and he knows of his allergy and that was why he requests a new tray. Resident # 151 stated he was not concerned about this matter for himself but concerned about other residents whose cognition level was not the same as his.<br><br>(continued on next page) |

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| --- | --- | --- | --- |
| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 11/14/2024 at 12:05 PM the DDS stated residents who have food allergies had the food allergy documented on the meal tray for the staff to see. The DDS stated before the meal tray reached the resident it went through 4 checkpoints of different staff members. The DDS stated first the cook checked the tray while they are making it, secondly the diet aide check the tray when it was received from the cook, thirdly the nurse check the meal trays for accuracy when they arrive to the unit, and fourthly the CNA checked the meal tray prior to giving it to the resident. The DDS stated that all dietary staff are trained on food allergies in the new employee training and during in-service trainings held with the department. The DDS stated in-service trainings are conducted biweekly with staff over varying topics. The DDS stated they were aware Resident # 151 had received beets on his meal tray at times. The DDS stated after they were notified of this occurring that additional in-service training had been conducted regarding food allergies. The DDS stated if residents receive meal trays with items, they are allergic to this could negatively affect residents because it could make them very sick, put them in the hospital, or even death. The DDS stated it was their responsibility to ensure that the dietary staff had been trained on food allergies.<br><br>In an interview on 11/14/2024 at 3:45 PM the DON stated resident meal trays are checked by dietary and then by nursing to ensure accuracy of texture, allergies, and diet type. The DON stated if residents received food items, they were allergic to it could negatively affect them by making them sick. DON stated they had been made aware of Resident # 151 receiving beets on their meal tray and that further training had been conducted with staff and that documentation of the training was in the in-service binder.<br><br>In an interview on 11/14/2024 at 4:30 PM the ADM stated it was their expectation that for residents with food allergies that the meal ticket slips had the food allergies documented on the resident meal slip and that the residents did not receive food items they were allergic to. The ADM stated it was the DDS, Cook, Diet Aide, Nurse, and CNA responsibility to ensure the resident meal tray was accurate and they did not receive food items they were allergic to. The ADM stated residents receiving food items they were allergic to could negatively affect them in that the resident would have a negative health outcome.<br><br>Review of grievance log reflected no grievances recorded regarding food allergies.<br><br>Review of in-service trainings with topic of resident allergies conducted on date 8/9/2024 with 13 dietary staff in attendance, 10/17/2024 with 30 nursing staff in attendance, 11/7/2024 with 12 dietary staff in attendance.<br><br>Review of tray line audit policy dated 6/17/2009 and revised on 8/22/2012 reflected under heading policy: A tray line audit to check for therapeutic diet accuracy, menu accuracy, portion control and food preferences will be conducted in accordance with the Quality Assurance Report Schedule, or more frequently if the consultant dietitian identifies ongoing problems. Under heading procedure:<br><br>1.<br><br>1. When tray line begins, stand at the end of the tray line and check a pre-selected number of trays. This review will include:<br><br>a. Checking the diet order on the tray card to the diet served on the tray, including:<br><br>(continued on next page) |

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|---|---|

F 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

1. Orders for therapeutic diets

2. Likes/dislikes

3. Allergies

.

Any other restrictions or additions noted on the tray card.

b. Note any errors in the above areas on the Quality Assurance Monitor II form.

2. Total and score the results of the review when completed.

3. Following the audit, review the results of the tray line audit with the DDS. Develop a plan of correction for any problems noted with the assistance of the DDS and will follow-up on the plan of correction within one to two weeks.

4. Include a copy of the audit and the plans of correction in the monthly report to the ADM.

Review of the undated Quality Assurance Monitor II form revealed no identified concerns, patterns, or trends.

Review of tray line service policy dated 12/01/2011 reflected under heading policy: The consultant dietitian will monitor the tray line to ensure that diets are served accurately and in the correct portions and that patient/resident preferences are met. See Section 6 for Quality Assurance Monitor forms and schedule. The following guidelines should be followed. Under heading guidelines:

1. A dated copy of the daily menu extensions with any changes is posted in the kitchen near the tray line so that the servers can use the extensions to correctly serve the diets.

2. The trays are prepared by the server using the diet extensions and the portion sizes listed on the extensions.

3. Staff on the tray line check each resident's tray card to ensure that dietary preferences and dislikes are honored, and appropriate substitutions provided.

4. Each tray is checked by the tray line personnel to ensure that the diet is served as ordered, the portion size of each item is correct, and preferences are met.

5. The Dietary Manager conducts a tray line audit once each week for each meal to ensure that diets are served correctly and to identify any training needs. See Section 6, Quality Assurance, for a sample Tray Line Audit form.

Review of Allergy Aware posting in kitchen undated reflected under heading Know your menu: 9 allergens-milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, soy, sesame. Under heading when a customer informs you of a food allergy:

(continued on next page)

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Refer food allergy concern to person in charge<br><br>-Remember to check the food preparation procedures for any possible cross contact, which can, include frying the items in question in the same oil as an item that contains an allergen.<br><br>- If a food item is returned to the kitchen due to an allergen, Do Not attempt to remove the allergen and send the food back. Trace amounts of allergens can trigger an allergic reaction. Under heading symptoms: If a guest has a reaction, call 911 immediately<br><br>-rash, hives, itching, tingling, swelling, wheezing, difficulty breathing, loss of consciousness, anaphylaxis.<br><br>50176 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917<br><br>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation.<br><br>1. The facility failed to ensure sanitation practices cleaning the ice machine, cleaning the cooktop range drip pans, utilization of an ice scoop receptacle that was not cracked and broken on the bottom were used.<br><br>2. The facility failed to label and date all food items in the kitchen.<br><br>3. The facility failed to refrigerate products after opening per the manufacturer label.<br><br>4. The facility failed to ensure food items were covered, secured and stored properly.<br><br>These failures could place residents at risk of foodborne illness.<br><br>Findings included:<br><br>Observation on 11/12/2024 at 9:19 AM revealed an ice scoop storage receptacle had cracks and pieces missing from the bottom of the storage receptacle.<br><br>Observation on 11/12/2024 at 9:20 AM revealed the inside of the ice machine had a brown and white substance on the upper inside of the door.<br><br>Observation on 11/12/2024 at 9:21 AM the lower shelf of prep table in main part of kitchen had a bus tub of individually wrapped slices of wheat bread with a food label that did not include the following information: preparation date, time, product name, or discard date.<br><br>Observation on 11/12/2024 at 9:25 AM the stovetop range revealed the drip pans had orange and brown dried food particles and substances and on foil liners.<br><br>Observation on 11/12/2024 at 9:31 AM of dry storage area revealed:<br><br>1. A gallon bag of coconut flakes with date of 7/1/24 (unsure if this is open date or use by date)<br><br>2. A gallon bag of yellow cake mix with date of 11/5/24 (unsure if this is open date or use by date)<br><br>3. A gallon bag of carrot cake mix with a date of 8/14/24 (unsure if this is open date or use by date)<br><br>4. A wrapped package of gravy mix with a date of 10/15/24 (unsure if this is open date or use by date)<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 5. A wrapped package of fettuccine noodles dated 11/7/24 (unsure if this is open date or use by date)<br><br>6. A gallon bag of elbow macaroni noodles dated 10/26/24 (unsure if this is open date or use by date)<br><br>7. A gallon jug of Italian dressing dated 9/12/24 that had been opened and was half full. Manufacturer label says to refrigerate after opening.<br><br>8. A 50 lb. bag of dry pinto beans tied close with plastic wrap unlabeled and undated, bag was half full.<br><br>9. A bag of yellow cornmeal loosely tied with plastic wrap unlabeled and undated, bag was half full.<br><br>10. A gallon jug of Teriyaki marinade & sauce undated and unlabeled that had been opened and was less than half full. Manufacturer label says to refrigerate after opening.<br><br>11. A gallon jug of soy sauce dated 12/11/2023 that had been opened and was less than half full. Manufacturer label says to refrigerate after opening.<br><br>Observation on 11/12/2024 at 9:38 AM of walk-in refrigerator revealed a steam table pan of meatballs with a label of item being salsa, prep date of 11/11/2024 no discard date recorded.<br><br>In an interview on 11/14/2024 at 12:05 PM the DDS stated their expectation for labeling and dating of food products in the kitchen was that items would be dated upon receipt, then dated again when prepared with prep date and discard date. The DDS stated they expected all food items to be labeled and dated. The DDS stated staff was trained on labeling and dating during their new employee on the job training and during in-service training that they conduct with staff. The DDS stated it was their responsibility to ensure the staff are trained on labeling and dating of food items. The DDS stated it could negatively affect residents if food items are not labeled and dated by residents getting sick and going to the hospital or possibly death.<br><br>In an interview on 11/14/2024 at 4:30 PM the ADM stated their expectation for labeling and dating of food products in the kitchen was that all food items were labeled and dated. The ADM stated it was the DDS, Assistant DDS, and all the staff responsibility to ensure this occurred. The ADM stated it could negatively affect the residents if food items were not labeled and dated by them having a negative health outcome.<br><br>Review of daily kitchen cleaning schedule dated November 2024 week 3 reflected under item stove and cooks area had been completed with cook initials for Monday. Further review revealed the ice machine was not on the cleaning schedule.<br><br>Review of In-service records reflected the following:<br><br>5.6.24 training topics: labeling, dating, storage, hazardous food storage, and sanitation with 12 staff in attendance<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 6.3.24 training topics: sanitation, labeling, dating, and hazardous food storage with 11 staff in attendance<br><br>7.3.24 training topic: proper sanitation with 13 staff in attendance<br><br>7.8.24 training topics: sanitation and labeling with 13 staff in attendance<br><br>Review of Food Storage policy dated 12/01/2011 reflected under heading policy: The consultant dietitian will monitor the storage of foods to ensure that all food served by the facility is of good quality and safe for consumption. All food will be stored according to the state and Federal Food Codes. The following guidelines should be followed. Under heading Guidelines:<br><br>1. Dry storage rooms<br><br>d. To ensure freshness, opened and bulk items are stored in tightly covered containers.<br><br>All containers are labeled and dated.<br><br>f. Where possible, items are left in the original cartons placed with the date visible.<br><br>g. The first-in, first-out (FIFO) rotation method is used. Packages are dated and new<br><br>items are placed behind existing supplies, so that the older items are used first.<br><br>2. Refrigerators<br><br>a. All refrigerated foods are stored per state and federal guidelines.<br><br>e. All refrigerated foods are dated, labeled, and tightly sealed, including leftovers, using<br><br>clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours. Items that are over 48 hours old are discarded.<br><br>Record review of FDA Food Code 2022 reflected established standards for food safety to protect public health.<br><br>3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and<br><br>Segregation.<br><br>(A) FOOD shall be protected from cross contamination by:<br><br>(1) Except as specified in (1)(d) below or when combined as ingredients,<br><br>separating raw animal FOODS during storage, preparation, holding, and<br><br>display from:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such<br><br>as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO EAT FOOD such as fruits and vegetables,<br><br>(b) Cooked READY-TO-EAT FOOD, and<br><br>(c) Fruits and vegetables before they are washed;<br><br>(d) Frozen, commercially processed and packaged raw animal FOOD<br><br>may be stored or displayed with or above frozen, commercially<br><br>processed and packaged, ready-to-eat food (2) Except when combined as ingredients, separating types of raw animal<br><br>FOODS from each other such as beef, FISH, lamb, pork, and POULTRY during<br><br>storage, preparation, holding, and display by:<br><br>(a) Using separate EQUIPMENT for each type, or<br><br>(b) Arranging each type of FOOD in EQUIPMENT so that cross<br><br>contamination of one type with another is prevented, and<br><br>(c) Preparing each type of FOOD at different times or in separate<br><br>areas;<br><br>(3) Cleaning equipment and utensils as specified under 4-602.11(A) and<br><br>sanitizing as specified under S 4-703.11;<br><br>(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of<br><br>this section, storing the food in packages, covered containers, or<br><br>wrappings;<br><br>(5) Cleaning hermetically sealed containers of food of visible soil before<br><br>opening;<br><br>(6) Protecting food containers that are received packaged together in a<br><br>case or overwrap from cuts when the case or overwrap is opened;<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | (7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under S 6-404.11; and<br>(8) Separating fruits and vegetables, before they are washed as specified under S 3-302.15 from READY-TO-EAT FOOD.<br>(B) Subparagraph (A)(4) of this section does not apply to:<br>(1) Whole, uncut, raw fruits and vegetables and nuts in the shell, that require peeling or hulling before consumption;<br>(2) PRIMAL CUTS, quarters, or sides of raw MEAT or slab bacon that are hung on clean, SANITIZED hooks or placed on clean, SANITIZED racks;<br>(3) Whole, uncut, processed MEATS such as country hams, and smoked or cured sausages that are placed on clean, SANITIZED racks;<br>(4) FOOD being cooled as specified under Subparagraph 3-501.15(B)(2); or<br>(5) SHELLSTOCK.<br>3-302.12 Food Storage Containers, Identified with Common Name of Food.<br>Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD.<br>3-602.11 Food Labels.<br>(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | (B) Label information shall include:<br><br>(1) The common name of the FOOD, or absent a common name, an<br><br>adequately descriptive identity statement;<br><br>(2) If made from two or more ingredients, a list of ingredients and sub ingredients in descending order of predominance by weight, including a<br><br>declaration of artificial colors, artificial flavors and chemical preservatives,<br><br>if contained in the FOOD;<br><br>(3) An accurate declaration of the net quantity of contents;<br><br>(4) The name and place of business of the manufacturer, [NAME], or<br><br>distributor; and<br><br>(5) The name of the FOOD source for each MAJOR FOOD ALLERGEN<br><br>contained in the FOOD unless the FOOD source is already part of the<br><br>common or usual name of the respective ingredient. Pf<br><br>(6) Except as exempted in the Federal Food, Drug, and Cosmetic Act<br><br>S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food<br><br>Labeling and 9 CFR 317 Subpart B Nutrition Labeling.<br><br>(7) For any salmonid FISH containing canthaxanthin or astaxanthin as a<br><br>COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of<br><br>ingredients, displayed on the retail container or by other written means,<br><br>such as a counter card, that discloses the use of canthaxanthin or<br><br>astaxanthin.<br><br>(C) Bulk FOOD that is available for CONSUMER self-dispensing shall be prominently<br><br>labeled with the following information in plain view of the CONSUMER:<br><br>(1) The manufacturer's or processor's label that was provided with the<br><br>FOOD; or<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | (2) A card, sign, or other method of notification that includes the<br>information specified under Subparagraphs (B)(1), (2), (5) and (6) of this<br>section.<br>(D) Bulk, unPACKAGED FOODS such as bakery products and unPACKAGED FOODS<br>that are portioned to CONSUMER specification need not be labeled if:<br>FDA Food Code 2022 Chapter 3. Food<br>Chapter 3 - 38<br>(1) A health, nutrient content, or other claim is not made;<br>(2) There are no state or local LAWS requiring labeling; and<br>(3) The FOOD is manufactured or prepared on the PREMISES of the FOOD<br>ESTABLISHMENT or at another FOOD ESTABLISHMENT or a FOOD PROCESSING<br>PLANT that is owned by the same PERSON and is regulated by the FOOD<br>regulatory agency that has jurisdiction.<br>3-602.12 Other Forms of Information.<br>(A) If required by LAW, CONSUMER warnings shall be provided.<br>(B) FOOD ESTABLISHMENT or manufacturers' dating information on FOODS may not<br>be concealed or altered.<br>(C) The PERMIT HOLDER shall notify CONSUMERS by written notification of the<br>presence of MAJOR FOOD ALLERGENS as an ingredient in unPACKAGED FOOD items<br>that are served or sold to the CONSUMER |

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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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872<br><br>Based on interview and record review, the facility failed to ensure the resident's medical records are accurately documented for 1 of 5 residents (Resident #13) reviewed for clinical records.<br><br>The facility failed to ensure Resident #13's Admission Agreement dated 8/26/24 signed electronically after consent received during phone conversation was witnessed by 2 people.<br><br>These failures could result in inaccurate records, errors in care, decline in health and quality of life.<br><br>Findings Include:<br><br>Review of Resident #13's face sheet revealed an 80-years-old male with admitted [DATE] with a discharge date of [DATE]. Diagnoses included: Hyperlipidemia (high level of lipids or fats in the blood), vascular dementia (memory and thought process difficulties related to multiple strokes, or loss of blood circulation to the brain), hypertension (high blood pressure), dysphagia (difficulty swallowing), and cognitive communication deficit (inability to communicate).<br><br>Review of Resident #13's initial minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 12 which indicated mild cognitive impairment.<br><br>Review of Resident #13's Care plan dated 8/27/24 revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, immobility, and physical limitations.<br><br>Review of Resident #13's Daily skilled note dated 8/26/24 at 12:25 PM revealed resident had impaired decision-making ability.<br><br>Review of Resident #13's Admission Agreement dated 8/26/24 revealed electronic signatures for Resident #13's FM 2 the ADMC and/or the ABOM on pages 4,5,6,7,8, 10 and 11.<br><br>Review of Resident #13's Power of Attorney dated 1/27/15, Resident #13 appointed his FM as power of attorney.<br><br>Interview on 11/14/24 at 11:16 AM with FM of Resident #13 revealed concerns with medical records. She stated she recently realized that no admission agreement had been signed when Resident #13 was admitted to the facility on [DATE]. Stated she did not think anything of it until recently when Resident #13 was admitted to a different facility.<br><br>(continued on next page) |

| 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 11/14/2024 |
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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 11/14/24 at 12:39 PM with the ADMC revealed the process for receiving consent for the admissions agreement was optimally done in person but if she was unable to get the resident to sign or see the family in the facility then she received consent by a phone conversation. The ADMC recalled calling phone number in chart for Resident #13 and spoke to a female to receive consent for admission on 8/26/24. She stated the FM 2 name was on the face sheet from the hospital along with the phone number. She stated she was unaware of any power of attorney at that time, as it was submitted later in the resident's stay. The ADMC stated after she talked to the female individual on the phone, she had assumed it was the FM 2 of the resident and placed her name in the electronic document. She further stated the phone number for the FM 2 and the FM were the same, so she was unsure if she spoke with the FM or the FM 2. She stated the system required 2 facility employees/witnesses to sign off on the document since the family member was not able to sign in person. She stated after she received consent for the admissions agreement, she signed off on it and sent it to the ABOM for his signature in the 2nd witness area. When asked if the ABOM witnessed the call to verify who the conversation was with she stated, he did not witness the conversation. The ADMC stated I think the system just wants 2 facility representatives not necessarily a witness. That's just how the form is set up.

Interview on 11/14/24 at 2:47 PM with ABOM revealed he did not remember witnessing the conversation with Resident #13's family member regarding the admission agreement. He stated the process for signing the admission agreement was the ADMC talked to the family and gets verbal consent then the system sends him a notification. He then reviewed the form and signed it. He stated he does not actually witness any of the conversations between the family and the ADMC. The ABOM stated he was unsure of who the ADMC talked to in order to receive consent for the admission agreement. He stated he did sign the form even though he did not witness the conversation about the admission agreement. He stated this could affect the residents if the situation did not fit the resident's needs. ( No further elaboration was given.)

Interview on 11/14/24 at 4:39 PM with ADM revealed his expectation for staff when obtaining consent for admissions agreements was to utilize Docusign. Stated in many cases the responsible parties for the residents are not local. His preference for obtaining consent was encourage the responsible party to come to the facility and sign in person, but if they are unable to then consent must be made by other means. He stated he expected staff to follow the policy.

Review of policy titled Documentation in Medical Record dated 10/24/22 stated:

Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

Policy Explanation and Compliance Guidelines:

1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.

2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.

3. Principles of documentation include, but are not limited to:

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | .<br><br>b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. |

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097

50872

Based on observations, interviews and record review, the facility failed to maintain an Infection Control Program designed to ensure hand hygiene procedures were followed by staff in the direct care of 5 of 15 residents (Resident #6, Resident #48, Resident #64, Resident #108, and Resident #292) reviewed for infection control in that:

1. CNA V did not sanitize or wash hands in between giving Resident # 48, Resident # 64 and Resident #108's meal trays, placing residents at risk of getting sick from food contamination.

2. CNA O failed to perform proper hand hygiene practices during peri care for Resident #6

3. The facility failed to ensure Resident #292 received indwelling urinary catheter care to maintain his catheter free of a moderate build-up of a dark brown colored substance.

This failure could place all residents at risk of getting sick and risk of transmission of diseases and infection.

The findings were:

1. Observation of lunch trays being passed on 11/12/2024 at 12:33pm revealed that CNA V did not wash or sanitize her hands in between giving Resident # 48, Resident # 64 and Resident #108's meal tray. She was observed getting Resident #48's meal trays and setting it up for him. She then got Resident #108's meal tray and set his up for him. Finally, she got Resident #64's meal tray and set it up for her. CNA V did not wash or sanitize her hands in between the meal trays.

An interview with CNA V on 11/14/2024 at 9:03am revealed she had been trained of infection control and hand hygiene. She stated that staff were to wash or sanitize their hands in between each tray. She said for every three sanitized hands the staff was supposed to wash with soap and water. She said that the nurse was responsible for monitoring to ensure staff were following the policy for hand washing. She also said if staff did not follow proper hand hygiene it could cause the resident's food to become contaminated. She said that she did not sanitize or wash her hands in between the resident's trays because she forgot.

An interview with LVN B on 11/14/2024 at 9:09am revealed she had been trained on infection control. She said the policy was for staff to use sanitizer in between each meal tray. She said staff were to wash their hands before they started to pass the meal trays and then they could use hand sanitizer in between each tray. She said that if staff do not use proper hand hygiene it could cause the resident's food to become contaminated. She said the nurses were to monitor the aides to ensure they are performing proper hand hygiene and for the nurses the DON monitors them. She said hand hygiene was monitored through observation. She said she thought that the aide just forgot to wash or sanitize her hands.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with the ADM on 11/14/2024 at 1:19pm revealed he had been trained on infection control. He stated staff should sanitize their hands before meal service. He also said two hand sanitizes to every hand wash. He said that the potential risk would be a break in infection control. He said monitoring of proper hand hygiene was the DON or designee's responsibility. He said the charge nurse would observe and instruct staff on hand hygiene. He also said he did not know why staff did not wash or sanitize their hands between meal trays.<br><br>2. Review of Resident #6's face sheet revealed a [AGE] year-old female with admitted [DATE]. Diagnosis includes diabetes mellitus (difficulty with regulating blood sugar levels), dementia (difficulty with memory and thought process), chronic obstructive pulmonary disease (a progressive disease that affects the way lungs process oxygen).<br><br>Review of Resident #6's quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 14 indicating cognitive impairment. MDS revealed Resident #6 needed maximal support or was completely dependent for activities of daily living. MDS revealed Resident #6 was frequently incontinent.<br><br>Review of Resident #6's Care Plan dated 10/1/18 revealed Resident #6 has bladder and bowel incontinence related to dementia, chronic obstructive pulmonary disease, and diabetes mellitus. The goals included the resident will remain free from skin breakdown due to incontinence and brief use through the review date. The interventions included: Cleanse peri-area with each incontinent episode. Check every 2 hours and as required for incontinence. Wash, rinse, and dry perineum (area around genitals). Change clothing as needed after incontinence episode. Monitor and document signs and symptoms of urinary tract infection.<br><br>Observation on 11/13/2024 at 9:54 AM, CNA O and CNA Q put on gloves while walking into room (no observation of hand hygiene) and worked together to connect the Hoyer sling under Resident #6 to the Hoyer lift and transfer the resident from wheelchair to bed. The sling was then disconnected from the Hoyer lift and the resident's shoes were removed. CNA Q left the room. CNA O raised the bed with same gloves on (gloves should have been removed and hand hygiene performed) and grabbed supplies out of dresser. He then placed all the supplies on a pad that was laying across the over the bed table. CNA O rolled Resident #6 to left side to roll up Hoyer sling. Resident #6 was rolled to the right side and the sling was removed from under Resident #6. CNA O then repeated the process to remove Resident #6's pants. CNA removed gloves(no observation of hand hygiene). Placed wedges under the sheet near the edge of the bed and walked out of the room. CNA O returned to the room while applying gloves. The CNA then placed a sheet over the lower half of Resident #6. CNA O unfastened the right side of the brief, opened the single use wipes and laid several wipes out individually on the pad across the table. CNA O unfastened the left side of the brief and rolled the brief up between Resident #6's legs. CNA O then picked up a disposable wipe and wiped down the left groin, folded the wipe, wiped the right groin. Wipe was disposed of, and new wipe obtained. CNA O then cleaned vaginal area wiping front to back using a new wipe each time. Resident #6 rolled on her left side, the brief was removed and disposed of in trash can. CNA O grabbed a new wipe and wipes buttocks 3 times folding the wipe in between each swipe. CNA O removed gloves (no hand hygiene performed) and applied new gloves. CNA O placed new brief under Resident #6 and secured it using the tabs. Resident #6 was then covered with a blanket and bed was returned to low position. CNA O removed gloves (no hand hygiene performed).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 11/13/24 at 10:14 AM with CNA O stated hand hygiene should have been performed before peri care, when changing gloves, and after peri care. CNA O stated that wipe should only be used one time only and not to be folded and reused. He stated that not following such practices could lead to infection. CNA O stated he has performed skills check off on peri care.<br><br>An interview with the DON on 11/14/2024 at 9:25am revealed she had been trained on infection control. She said the policy for hand hygiene during meal service was staff were supposed to sanitize their hands between each meal tray. She also said after the third tray and sanitize staff were to wash their hands. She said if staff did not follow proper hand hygiene it could cause infections. She said that the DON and ADON were responsible for monitoring hand hygiene. She said this was done through audits and taking the staff to demonstrate proper hand washing. She said that she thought that staff were nervous and forgot to wash and sanitize their hands.<br><br>An interview on 11/13/24 at 1:29 PM, the ADON revealed staff are to use disposable wipes one time and throw them away. The ADON also stated hand hygiene was supposed to be performed before and after contact with residents and when changing gloves. He stated not doing so left the residents at risk for infection.<br><br>3. Review of Resident #292's face sheet revealed a [AGE] year-old male with an admitted [DATE]. Diagnosis includes retention of urine (the inability to urinate normally), absence of kidney, diabetes mellitus (inability to regulate the blood sugar level), and hyperlipidemia (a condition of higher-than-normal level of fats in the blood).<br><br>Review of Resident #292's record indicates no MDS as resident was admitted 4 days prior.<br><br>Review of Resident #292's care plan dated 11/9/2024 revealed the resident has Indwelling Catheter. The goal included the resident will show no sign or symptom of urinary infection through review date and the resident will be/remain free from catheter-related trauma through review date. Interventions included Monitor for signs or symptoms of pain/discomfort due to catheter.<br><br>During interview on 11/13/24 10:43 AM, Resident #292 stated that no one has cleaned his catheter before, and no one has explained how to clean it appropriately. Resident #292 stated it was painful for the catheter to be cleaned a few minutes ago.<br><br>An interview on 11/14/24 at 11:40 AM, the DON stated there was not a specific policy for catheter care.<br><br>An interview on 11/14/24 at 4:39 PM, the ADM stated he expected all worker to work within their scope of practice and training. He stated all catheters should be cleaned at least daily. He expected the CNAs to follow policy when performing peri-care and not doing so could lead to infection.<br><br>Record review of Peri care policy dated 10/24/22 revealed It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown. Policy Explanation and compliance guidelines stated:<br><br>.<br><br>(continued on next page) |

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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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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate.<br><br>.<br><br>10. Change gloves if soiled and continue with perineal care.<br><br>11. Females:<br><br>a. Assist resident in bending her knees slightly and spreading her legs.<br><br>b. Open wipes package and obtain the wet cloth.<br><br>c. Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (pubic area to the anus).<br><br>d. Repeat on opposite side using a new disposable wipe.<br><br>e. Clean urethral meatus and vaginal orifice using a new disposable wipe with each stroke.<br><br>.<br><br>Record Review of Hand Washing Policy dated 10/24/2022 revealed all staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents and visitors. |

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F 0912

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.

50176

Based on observation, interviews, and record review, the facility failed to provide the required 80 square foot per resident in 5 of 5 resident rooms (room numbers 201, 404, 504, 2405, and 2505), reviewed for environment.

The facility failed to provide 80 square feet per resident in 5 shared resident rooms.

This failure could affect residents who resided in the facility and could result in inadequate space for resident's activities of daily living in their rooms.

Findings included:

During observations on 11/12/2024 during initial pool screening, rooms 201, 404, 504, 2405, and 2505 were observed to have three beds/three residents in the room. The beds were positioned parallel to each other in a row with one bed near the door, one bed in the middle, and one bed next to the window. The positioning of the beds allowed for Bed B, which was the middle bed, to have significantly smaller living space than the other two beds in the room.

During an interview with the ADM on 11/12/2024 at 3:54 PM, the ADM stated he did not have any room waivers nor room variations. The ADM stated this had not been an issue in the past and stated his Bed Classification form allows 3 residents in rooms 201, 404, 504, 2405, and 2505. The ADM stated that he measured one room, and it was 261 square feet, which would equal more than 80 square feet per resident.

During an observation on 11/13/2024 between 10:07 AM and 10:50 AM, the Maintenance Assistant measured the five rooms with a digital laser measure.

Review of digital measurements revealed the square footage of 5 sampled room measurements were as followed:

*201 - 254.31 (room total)

201A - 85.39

201B - 71.80

201C - 90.03

*404 - 263.11 (room total)

404A - 92.71

404B - 72.47

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| | 455599 | A. Building<br>B. Wing | 11/14/2024 |

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| F 0912<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 404C - 95.62<br><br>*504 - 261.42 (room total)<br><br>504A - 92.51<br><br>504B - 76.98<br><br>504C - 94.96<br><br>*2405 - 147.24 (room total)<br><br>2405A - 91.75<br><br>2405B - 74.00<br><br>2405C - 96.55<br><br>*2505 - 143.94 (room total)<br><br>2505A - 116.40<br><br>2505B - 48.84<br><br>2505C - 97.81<br><br>During an interview with the DON on 11/14/2024 at 3:36 PM, the DON stated she was not aware of any room waivers or variances, and she did not know the required square footage of resident's bedroom living space until the surveyor told her. The DON stated having less than 80 sq feet could impair the resident's ability to move around the room and get ADL care.<br><br>During an interview with the ADM on 11/14/2024 at 4:17 PM, the ADM stated he was not aware that some resident's bedroom living space was less than 80 square feet. The ADM stated that if a resident complained about the space, he would move the resident to a different room, which had happened in the past. The ADM stated that some residents enjoyed the middle Bed B and did not complain.<br><br>Record review of the facility Bed Classification form dated 11/12/2024 revealed 5 resident rooms were certified as rooms for 3 residents. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872<br><br>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.<br><br>The facility failed to have pest control effectively treat the building for insects.<br><br>These deficient practices placed residents at risk of exposure to pests, diseases, infections, and diminished quality of life.<br><br>Findings included:<br><br>Observation on 11/12/24 at 9:15 AM, there was a fly, flying around on 300 halls, outside of room [ROOM NUMBER] by the meal service cart.<br><br>Observation on 11/12/24 at 9:58 AM, revealed 4 gnats flying around the tea urn and landing on the wall and counter in the dining room.<br><br>Observation on 11/12/2024 at 11:56 AM revealed Resident #142 had visible flies and gnats on cups that were sitting on the bedside table. The cups had coffee and a clear liquid. He had three flies that were flying around the resident's lower extremities above the blanket. Flies were landing on and off his exposed chest.<br><br>Observation on 11/13/24 at 8:24 AM, there was a small brown and black roach crawling on the conference room wall.<br><br>Observation on 11/13/24 at 8:30 AM, there was a small black roach crawling across the table in the conference room.<br><br>Observation on 11/13/24 at 9:20 AM, there was a small black roach crawling across the table in the conference room.<br><br>Observation and interview on 11/13/24 at 11:58 AM revealed in Resident #54's room gnats were next to her refrigerator. The resident voiced she thought they are from her refrigerator because it would not close.<br><br>Observation on 11/13/24 at 01:17 PM revealed on Resident #142's bedside table were flies and gnats and flying on his bedsheets.<br><br>Observation on 11/13/24 at 04:02 PM revealed flies and gnats flying around coffee and juice on Resident #142's bedside table; flying on bedsheets; and landing on his skin periodically.<br><br>Observation on 11/14/24 at 9:15 AM, there was a fly on the inside of the window in the conference room.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 11/14/24 at 4:43 PM during interview with ADM revealed a gnat flying around the conference room.<br><br>During an interview on 11/14/24 at 09:15 AM Charge nurse A sated the gnats and flies were in resident rooms because Maybe because it is dirty could be a reason there are gnats. For the flies maybe for the same reason. If gnat can mean, there is something sweet in the room that they like.<br><br>She stated, It's uncomfortable.<br><br>During an interview on 11/14/24 at 4:39 PM the ADM revealed the facility had been treated for pests. The ADM stated the facility was going to increase the frequency and amount of pest treatments. The ADM stated he was surprised to see any pests. The ADM stated I have no idea how the residents felt about flies and gnats flying on their bedside table, landing on their bedsheets and skin. The administrator stated pests could cause infection.<br><br>During interview on 11/14/24 at 11:40 AM, the DON stated there was no specific policy for pest control.<br><br>Record review of resident council meeting minutes revealed the following:<br><br>*Dated 08/21/2024 revealed increase roach infestation .advised to write grievance to administrator. Resident council meeting minutes<br><br>*Dated 09/18/2024 revealed residents complained the roaches are horrible.<br><br>*Dated 11/13/2024, during the resident council meeting, several residents complained about the roaches.<br><br>Record review of the pest control invoices indicated the following:<br><br>* Dated 8/21/24 revealed service description as follow up for small cockroaches. Comments included Inspected and treated kitchen, dish pit room, tray return room, dry storage, kitchen office and service hallway for German roaches. Activity has drastically gone down. Replaced a few insects monitors as needed. Dusted cracks and crevices in base boards, wall boards, and equipment. Treated all baseboard perimeters, behind and under equipment, office, dry storage, and service hallway with a chemical residual and insect growth regulator. Will follow up next Wednesday.<br><br>*No pest invoice provided for 8/22/24-9/29/24.<br><br>* Dated 9/30/24 revealed service description as Flying insect program and Regular pest service. Comments included inspected and serviced exterior perimeter and rodent bait stations. Inspected and serviced interior kitchen areas, dining rooms, employee areas, restrooms, nursing stations and entryways. Activity was observed on insect monitors in kitchen. Treated these areas with liquid application. Replaced glue boards in mechanical catch traps with no activity observed. Replaced glue boards in insect light traps with flying insect activity observed.<br><br>(continued on next page) |

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| 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 11/14/2024 |
|---|---|---|---|
| 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) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | * Dated 10/25/24 revealed service description as flying insect program and regular pest service. Comments included Inspected and serviced exterior perimeter and rodent bait stations. Replaced old bait with no activity observed. Baited perimeter with granular bait for large cockroaches, occasional invaders, and ants. Inspected and serviced interior kitchen areas, dining room, entryways, restrooms, nursing stations, break room, closets, and other employee areas. Activity was observed in kitchen. Liquid application was applied throughout, and placed insect monitors out. Replaced glue boards in mechanical catch trap with no activity observed. Replaced glue boards in insect light trap with flying insect activity observed.<br><br>* Dated 11/13/24 revealed emergency service for small flies. The tech comment on the invoice included complaints were from the coffee/tea area in 1st & 2nd floor dining rooms. Recommend removing bins from counter and cleaning them well. As well as discarding trays with food on them that are stacked on the same counter. Aerosol was used for knocking down and applied liquid application in these areas. Placed fly bait throughout. Spoke to [MD] upon arrival. Did a thorough inspection and could not find him again. Treated upstairs conference room as a request from [MD]. |