

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Juniper Village at Spicewood Summit		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 Spicewood Springs Rd Austin, TX 78759	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 1 of 1 dining room reviewed for environment.</p> <p>The facility failed to ensure the roof/ceiling of the dining area did not leak during a rainstorm on 05/05/25.</p> <p>This failure placed residents at risk of discomfort and diminished quality of life.</p> <p>Findings included:</p> <p>Observation on 05/05/25 at 12:10 PM revealed the facility dining room had two main seating areas which both led into a side room with a slanted ceiling and windows wrapped around all sides. The ceiling was composed of large planks laid side by side, and the seam between the second and third planks dripped heavily into the room and onto the floor. The room did not contain residents but was visible from the resident seating areas, and several residents were heard to remark on the leak. The room did contain a hydration cart with an ice chest, ice scoop, and disposable cups. CNA B was heard telling the other staff in the dining area she would retrieve a wet floor sign and towels. Two minutes later, she returned, threw towels down on the wet area, and set up a yellow wet floor sign on top of them. As she walked by, she stated we have been complaining about this.</p> <p>During observation and interview on 05/05/25 at 02:40 PM, the MAINT looked at the ceiling and stated he could see it was leaking and that the water had a slight tint to it. He stated the room was referred to as the screen room because it was like a screened in porch but completely enclosed. It was still raining lightly at the time, and the leak was much lighter than it had been earlier during the heavy rain. The MAINT stated that was the first he had heard of the leak in the roof. He stated any of the staff could enter a work order into the electronic work order system, and he had no work orders for this leak.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/06/25 at 12:43 PM, CNA C stated it did not rain very often, but she had seen the ceiling leak in the screen room once. She stated they had alerted management about it, and she thought the MAINT knew because she had seen him looking around the area the week before. She stated she was not completely sure what he had been looking at, as it had not been raining that day, and the ceiling was not leaking at the time. CNA C stated they had to speak to the nurses to let them know there was a problem. She stated she was not actually sure exactly what they should have done if they saw something that needed to be repaired, but she had spoken to HK D, who used to be the supervisor of housekeeping and maintenance. CNA C stated HK D was the supervisor of those departments for so long that staff just went to her automatically. CNA C stated she was not sure if the CNAs had the ability to enter work orders directly into the electronic work order system. She stated she was not aware of anyone slipping on the water when the ceiling leaked or of any resident areas being contaminated. She stated the residents noticed when it leaked and did not like it.</p> <p>During an interview on 05/07/25 at 11:15 AM, HK D stated she used to be the maintenance director in the facility and was aware of the leaking roof in the dining area. She stated they had gone outside the last time it rained hard and put some glue in the cracks to stop it from leaking. She stated when it rained hard, the water started coming in again. She stated the staff tried to come tell her about needed repairs, and she always directed them to the electronic reporting system. She stated she had educated the staff on using the electronic maintenance concern reporting system, and all of them should have known they could use it. She stated she was not aware of any resident ever being affected by the leak. She stated the residents did not eat in that area, and most of them did not see the leak.</p> <p>During an interview on 05/07/25 at 01:17 PM, the ADON stated she had noticed the leaking in the roof of the screen room. She stated she had not directly reported the leak or entered a maintenance request into the electronic maintenance request system. She stated she had heard other staff say they had reported the leak. The ADON stated the new maintenance director (MAINT) had instituted the electronic system, and anybody was able to enter the information. She stated it was a very simple system. She stated no resident had been affected, and there had been no slips or injuries as a result of the leak. She stated the leak could have had a negative impact on residents in that someone could have walked through the area and fell. She stated a leaking ceiling was not a good look for someone to have in their home.</p> <p>During an interview on 05/07/25 at 01:33 PM, the DON stated her first day in the facility had been 03/20/25, and she was not familiar with the process for reporting maintenance requests. She stated she knew they had the electronic reporting system, and all the staff was able to use it. She stated she would want to report the issue face to face to the MAINT. She stated she was not aware there was a leak in the ceiling of the dining room and was only just hearing about it during this interview. She stated something like that needed to be reported right away and fixed right away. She stated the potential negative impact of a leak in the dining was mold growth, exposure to bacteria, and even hypothermia.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/07/25 at 01:52 PM, the ADM stated the process of reporting a maintenance need was through the electronic reporting system, and any staff could do that. He stated his first day as administrator was the day the State Agency entered for survey, so he had not been at the facility long enough to develop oversight into the maintenance of the facility environment. The ADM stated he did not think the failure could have a negative impact on residents, as they did not use that space in the facility. He stated observing the ceiling leaking could have had a psychosocial impact on residents.</p> <p>Review of the work order list dated 05/05/25 reflected no orders related to a leaking ceiling or roof.</p> <p>Review of undated facility policy titled Quality of Life reflected the following:</p> <p>Policy: residents are cared for in a manner and in an environment, that promotes maintenance or enhancement of each person's quality of life.</p> <p>Purpose: To provide residents with a safe, supportive, comfortable, homelike environment; freedom and encouragement to exercise personal choice over their surroundings, schedules, healthcare, and life activities; the opportunity to be involved with the members of their community inside, and outside the nursing home; and treatment with dignity and respect.</p> <p>Procedure:</p> <p>E. Creation of an environment that is:</p> <ol style="list-style-type: none"> 1) Safe, clean, comfortable, and home like in which residences are allowed to use their personal belongings to the extent possible; 2) Maintenance of a sanitary, orderly, and comfortable interior. 		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 (Nurse Cart) of 5 Medication carts reviewed for drug storage.</p> <p>The facility failed to ensure that expired insulin pens were removed from the Nurse Cart on 05/06/25.</p> <p>This failure could place residents at risk for ineffective diabetes treatments and infections from contaminated insulin pens.</p> <p>Findings included:</p> <p>Observation on 05/06/25 at 02:30 PM revealed the Nurse Cart belonging to LVN-A contained two insulin pens with opened dates of 03/07/25. The facility sticker placed on each pen when it was opened stated, discard 28 days after opening which would have made the expiration date of the 2 insulin pens 04/04/25.</p> <p>In an interview with LVN-A on 05/06/25 at 2:35 PM she stated the policy was to discard insulin pens 1 month after opening because they could have become contaminated. She stated the negative outcome to residents if not discarded was they could get an infection if the pens became contaminated and were used past the expiration date. She acknowledged the cart was her responsibility but did not answer additional questions.</p> <p>In an interview on 05/07/25 at 01:26 PM, the ADON stated the policy for opening a new insulin pen was to date the pen when it was opened on a sticker and store it in the nurse's medication cart. She stated the insulin pen could be used for 28 days after opening, then it expired. She stated discontinued or expired medications should be placed in the discharge box in the medication room and it was the responsibility of the nurse to check that. She stated it is important to date and discard the pen after the discard date to ensure it maintains the right strength of the medication. Expired insulin pens could cause infection, inflammation or the medication may not work effectively. She stated the negative outcome to residents if expired pens were not discard could be ineffective treatment for diabetes or it could cause an infection control issue if it became contaminated while left open for the extended time.</p> <p>In an interview on 05/07/25 at 01:41 PM, the DON stated she started working here in March of this year. She stated the policy for opening a new insulin pen was to date the label on the pen or put a label on it to indicated when the pen was opened. She stated the insulin pen could be used for 28 days after opening. The DON stated expired or discontinued medications should be given to her for destruction and it was the responsibility of the nursing staff to check this. She stated it was important to date and discard the pen after the discard date to prevent cross contamination. She stated the medicine could degrade after the expiration. She stated they could not know how long the insulin was good after it was removed from refrigeration. She stated the negative outcome to residents if the expired insulin was used could be failure to lower the residents blood sugar effectively.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/07/25 at 02:13 PM, the ADM stated the policy for insulin was that it can be used for 30 days after it was opened. He stated that expired or discontinued medications should be given to the DON to dispose of, and that it was the responsibility of the nurses to check the medication carts for this. He stated it was important to date and discard the pen after the discard date so they don't give a resident expired medication, but he did not know exactly what the clinical outcome would be if the resident was given expired insulin.</p> <p>A record review of the facility undated policy labeled Residents Services Manual-Medications Storage reflected expired, discontinued and/or contaminated medications will be removed from the medication storage area and disposed of .</p> <p>A record review of the facility insulin sticker reflected that insulin was to be discarded 28 days after it was opened.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received food that accommodated their preferences for 2 of 24 residents (Residents #177 and #178) reviewed for food and nutritional services.</p> <p>The facility failed to ensure that Residents #177 and #178 were provided hot sauce or salsa with their Cinco de Mayo meal of Mexican food by request and in accordance with their cultural preferences.</p> <p>The failure placed residents at risk of not having their cultural needs met.</p> <p>Findings included:</p> <p>Review of the undated face sheet for Resident #177 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: anemia (low blood iron), end stage renal disease (kidney disease), type two diabetes mellitus (trouble producing insulin leading to high blood sugar), peripheral vascular disease (poor blood circulation to the arms and legs often leading to trouble healing wounds in those areas), anxiety disorder, cognitive communication deficit (communication difficulties caused by impaired cognition), and depression.</p> <p>Review of EHR for Resident #177 reflected no MDS assessment had been completed.</p> <p>Review of the care plan for Resident #177 dated 05/05/25 reflected the following: (Resident #177) is at risk for malnutrition following ESRD. Resident intake of nutrients will meet metabolic needs. If malnourished, consult dietitian.</p> <p>Review of the undated face sheet for Resident #178 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis following cerebral infarction (paralysis on one side of the body after the brain was deprived of oxygen leading to an area of brain death), hypertension (high blood pressure), and hyperlipidemia (high cholesterol).</p> <p>Review of EHR for Resident #178 reflected no MDS assessment had been completed.</p> <p>Review of the care plan for Resident #178 dated 05/06/25 reflected the following: Carb controlled regular texture, thin liquids. Resident's dietary goal- maintain current weight. Dietary interventions- eats in dining room.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the lunch meal service on 05/05/25 at 12:27 PM revealed Resident #177 was served a meal of chicken quesadilla, Mexican rice, refried beans, and salad. He asked for some hot sauce, and CNA B said to him, We don't have any hot sauce. Remember this morning at breakfast you asked, and we said we could not give you any? Resident #178 was served a plate with beef tacos, Mexican rice, refried beans, and salad. He asked for some hot sauce or salsa, and CNA B told him they did not have any to offer him. He said, How can I eat Mexican food without salsa? He had two FMs sitting at his table with him, and all three of them stated they identified as Hispanic and wanted to eat hot sauce with most meals but especially Mexican food. One of the visitors stated it was Cinco de Mayo, and they were serving Mexican food in honor of Cinco de Mayo, so they should have had hot sauce available.</p> <p>During observation of breakfast meal service and an interview on 05/06/25 at 08:15 AM, Resident #177 asked CNA C for hot sauce for his eggs. CNA C stated she was sure there was hot sauce available in the kitchen and told him she would go check as soon as she passed out all the other resident trays. Five minutes later, she came back from the kitchen (which was on the other side of the facility in the assisted living that shares a campus) with a bottle of hot sauce and gave it to Resident #177. He smiled broadly and thanked her.</p> <p>During an interview on 05/06/25 at 10:12 AM, Resident #177 stated Of course I like hot sauce! I'm a black man! I need flavor in my food! He stated he would survive, but some good hot sauce would make him like his food a lot more and probably eat more.</p> <p>During an interview on 05/06/25 at 12:43 PM, CNA C stated residents had particular preferences, and they often had a hard time getting staff to go the extra mile to obtain those preferences. She stated everyone knew Resident #177 had been asking for hot sauce ever since he came to the facility on [DATE]. She stated if a resident wanted something special, each staff member was responsible for taking the initiative to obtain it.</p> <p>During an interview on 05/06/25 at 01:10 PM, CNA B stated she had never seen hot sauce available for the residents. She stated she would ask the kitchen and they would say no they did not have any hot sauce. She stated when Residents #177 and #178 asked for hot sauce the day before, she did not ask the kitchen for any, because she had asked for it before and was told they did not have it. CNA B stated the CNAs were not allowed to go directly to the kitchen and had to ask the servers that work in the SNF satellite kitchen. CNA B stated if the aides did not listen to the servers and tried to walk up to the kitchen to ask for something themselves, they were told to send a server and they were sent back without the item. She stated she had worked at the facility for 13 years and did not remember the last time she tried to go to the main kitchen and ask for something.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/06/25 at 02:04 PM, the LCK stated they did not usually serve hot sauce, because most of the residents did not enjoy spicy foods, but he had heard that there were two residents wanting hot sauce in the SNF part of the building. He stated the process for ensuring cultural and other preferences was that, during admission, the nursing staff was to interview residents on their preferences. He stated the dietary information from that interview was to be sent to the kitchen to incorporate into meal service. He stated he had no information in his system about Residents #177 and 178 wanting hot sauce with their meals. He stated the CNAs could always get something from the kitchen, and there had never been a rule about them not approaching the kitchen. He stated if a resident wanted something additional with their food, they would always offer it if it was safe for the resident and would go get it from the store if they did not have it. He stated a potential negative impact of a resident not receiving the cultural food they wanted was they might become upset. He stated they tried to stress to all the staff that the residents often had few choices at this stage of their lives, and what they wanted to eat was one of the remaining choices. He stated it was very important to allow the resident to make those choices.</p> <p>During an interview on 05/06/25 at 02:14 PM, the DM stated the whole day on 05/05/2025 was about Cinco de Mayo, and he had residents asking about different types of Mexican foods. He stated the aides only needed to ask for something the residents wanted, and the kitchen would accommodate if the item was safe for the resident to eat. The DM stated the staff often did not want to go the extra mile to obtain the extra things the residents wanted, but the staff were required by the process to do that. The DM stated he was very new to the facility and had only been working there for a little over a week, but he could say that CNAs were welcome to come straight to the kitchen to ask for anything, including hot sauce. He stated the kitchen had hot sauce available, and if they did not have the type of hot sauce the resident wanted, they would get more. He stated the potential impact of not meeting a resident's cultural preferences for food was they could have mental anguish. He stated many of them already had disabilities, and to take away their sense of cultural identity was a form of torture. The DM stated he was responsible for ensuring resident preferences were accommodated, but he was still trying to put systems in place in the kitchen.</p> <p>During an interview on 05/07/25 at 01:17 PM, the ADON stated she heard Residents #177 and 178 asked for hot sauce for the first time on 05/05/25 and did not hear the staff's response. She stated she only knew they did not have hot sauce to offer the residents. She stated she was surprised to discover there was hot sauce in the facility all along and nobody tried to get it for the residents when they were eating Mexican food on Cinco de Mayo. The ADON stated there was no rule that CNAs could not go to the kitchen to ask for things. She stated the potential negative impact of not receiving cultural food preferences was the residents could enjoy their food less.</p> <p>During an interview on 05/07/25 at 01:33 PM, the DON stated she had not explored the facility system for ensuring diet preferences yet, as she was new and had been working on the nursing systems. She stated her practice and what she would expect of her staff would be they go ask the kitchen for anything the residents wanted. She stated the DM was responsible for that system, but he was also new. She stated a potential negative impact on the resident of not getting the cultural food they wanted was they might not feel regarded in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/07/25 at 01:52 PM, the ADM stated if residents had cultural dietary preferences, they only needed to ask the staff, and the staff had walkie talkies to request anything the residents requested from dietary. The ADM stated if it was something that the resident was safe to eat, given the diet they were on, the staff should have gotten it for them. If it was something the kitchen did not have available, the item should have been obtained. The ADM stated he had only been at the facility for three days, so he had not been able to monitor the system for compliance, but he felt the residents should receive what they asked for. He stated he could not think of a physical impact of the failure, but there could be a psychosocial impact of them not having their cultural needs met.</p> <p>Review of undated facility policy titled The Food Choices reflected the following: The overall dining experience for the residents includes the following components. Facility communities menu-- two separate seasonal select menus are developed with 5-week cycles, regional considerations, and diet extensions for heart healthy, no added sodium, consistent carbohydrate, Alzheimer's adapted, renal, modified texture and thickened liquid available. The menu program is a (web-based program) that is specifically developed with (food delivery company) and our Consultant Dietitian. The chef/dietary manager working with the residents in the food committee can adjust the menus based upon resident desire.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 2 kitchens (main kitchen) reviewed for food service safety.</p> <p>The facility failed to ensure, on 05/05/25 that:</p> <ul style="list-style-type: none"> - the ice cream freezer and dairy refrigerator surfaces were clean, - breakfast sausages and bacon were stored in a safe manner - milk and buttermilk were not stored in the facility dairy refrigerator past the Sell By dates. <p>This failure place residents at risk of food-borne illness.</p> <p>Findings included:</p> <p>Observation on 05/05/25 at 09:26 AM reflected the following conditions in the facility kitchen:</p> <ul style="list-style-type: none"> -an open cardboard box containing a plastic bag of breakfast sausages open to the air, not labeled or dated, in the walk-in refrigerator; -an upright, stainless steel, two-door ice cream freezer in the dry storage closet with sticky and crusted material covering the doors and door handles -a stainless steel pan of cooked bacon covered in plastic cling wrap and dated 05/04/25, was inside the facility oven -two gallons of milk in the dairy refrigerator dated 04/30/25 (one of which was open and partially used) and two gallons dated 05/01/25; six quarts of buttermilk dated 04/21/25 (one of which was open and partially used); and -crusted white substance covering the lowest shelf surface of the dairy refrigerator. <p>During an interview and observation on 05/05/25 at 09:47 AM, the DM stated the expired dairy products should not have remained in the refrigerator and should have been discarded. He threw them away.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/06/25 at 02:04 PM, the LCK stated he had worked at the facility since 1996. He stated the expired dairy in the refrigerator was expired, and should not have been used, but should have been discarded. He stated the sausage in the walk-in refrigerator should have been sealed, labeled, and dated. He stated the bacon in the oven was not proper storage of hazardous foods, and he did not know why it was there. He stated the dairy delivery person brought more milk than they could use. He stated they never used buttermilk for anything, so he was not sure why the delivery person brought it. The LCK stated he doubted the milk had been used while it was expired, because the servers in the kitchen served from different containers of milk out of the serving refrigerator in a different area of the dining room. He stated the stainless-steel equipment should have been cleaned daily and maintained in a clean state and hazardous foods needed to be stored properly, labeled, and dated. He stated all the cooks, and the DM were responsible for ensuring compliance with food safety guidelines. He stated the potential negative impact of the failures was residents could get sick, and they had compromised immune systems, which could make illness more dangerous.</p> <p>During an interview on 05/06/25 at 02:14 PM, the DM stated he had started at the facility a little over a week prior, and there was a lot of work to do to get the dietary systems into place. He stated he wanted the equipment cleaned on a cleaning schedule, and the stainless steel surfaces to be on a daily schedule. He stated there was not currently a daily or deep cleaning schedule for the kitchen staff. He stated the expired dairy products were the result of the dairy purveyor dropping off too much dairy, but it was the staff's responsibility to discard it once it passed the expiration date. He stated he was responsible for everything in the kitchen, including any non-compliance with food safety guidelines. He stated he did not think there would have been any negative impact on the residents, as none of the foods would have been served.</p> <p>During an interview on 05/07/25 at 01:52 PM, the ADM stated it was his third day, and he had been involved in the full book survey process since his first day, so he did not know all of the processes in place to keep the kitchen in compliance with food safety guidelines. He stepped away for a few minutes, returned, and stated there was no process in place currently of daily audits or checks on expired foods or improperly stored foods. He stated the potential negative impact of non-compliance with food safety guidelines was residents could get sick.</p> <p>Review of undated facility policy titled Storage-Refrigerator and Freezer reflected the following:</p> <p>Policy: all foods used in the dietary department I received, stored, and issued in a timely fashion to reduce deterioration, contamination, and loss.</p> <p>Purpose: to ensure safety</p> <p>Procedure:</p> <p>5. All walk in freezers and refrigerators are lit and kept clean.</p> <p>12. leftover foods are put in the refrigerator in shallow pans (2 to 4 inches deep) So the interior temperature of the food chills quickly to less than 40&deg;F. They are covered, dated, and labeled. They are not mixed with fresh foods.</p> <p>13. Leftover foods are refrigerated immediately and used within 48 hours.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Juniper Village at Spicewood Summit		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 Spicewood Springs Rd Austin, TX 78759	

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>18. All food items in the refrigerators are properly dated, labeled, and placed in containers with lids.</p>

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NAME OF PROVIDER OR SUPPLIER Juniper Village at Spicewood Summit		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 Spicewood Springs Rd Austin, TX 78759	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 2 of 2 dumpsters reviewed for garbage disposal.</p> <p>The facility failed to ensure the recycling and trash dumpster doors and windows were closed on 05/06/25.</p> <p>This failure placed residents at risk of pest infestation and disease.</p> <p>Findings included:</p> <p>Observation on 05/06/25 at 10:30 AM revealed the facility recycling dumpster was open at the top, and the facility trash dumpster was open at the top and on the side. Numerous flies were seen within the trash dumpster.</p> <p>Observation on 05/06/25 at 02:45 PM revealed the recycling and trash dumpsters were still open. There were still flies in the dumpster.</p> <p>During an interview on 05/06/25 at 02:04 PM, the LCK stated the kitchen trash was taken out by the dishwasher each day, but the nursing staff also used the dumpsters. He stated they were supposed to make sure the side and the top of dumpster was closed. He stated it was important to ensure they were closed so rodents, birds, and insects would not infest the trash and so trash would not fly out. He stated it was unsanitary to leave the dumpsters open. He stated it was everyone's responsibility to ensure the dumpsters were closed.</p> <p>During an interview on 05/06/25 at 02:14 PM, the DM stated the dumpsters should have been closed at the top and the sides. He stated they needed to be closed to prevent pests from getting in there. He stated the dumpster being open could create a bad smell for the residents and allow flies to get in and around the facility. He stated every employee should have responsibility for keeping them closed, but as the dietary manager, he needed to ensure they were closed. He stated he was brand new to the facility and still trying to figure out systems to ensure compliance.</p> <p>During an interview on 05/07/25 at 01:52 PM, the ADM stated the dumpsters needed to be shut according to policy. He stated there would be no potential impact in residents, because they did not go out into that area.</p> <p>Review of undated facility policy titled Waste Removal reflected the following:</p> <p>Policy: the community shall arrange for all solid or liquid waste, garbage, and trash to be collected, stored, and disposed of in accordance with the rules of the applicable state Department of environmental protection.</p> <p>Purpose: to ensure safety</p> <p>Procedure:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Juniper Village at Spicewood Summit		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 Spicewood Springs Rd Austin, TX 78759	

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Waste shall be stored in insect-proof, rodent proof, fireproof, non-absorbent, water type containers with tight fitting covers.</p>