

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Barton Valley Rehabilitation and Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Dudmar Dr Austin, TX 78735	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141</p> <p>Based on observations, interviews, and record review the facility failed to ensure residents had the right to and the facility promoted and facilitated resident self-determination through support of resident choice, which included but not limited to the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 5 residents (Resident #1) reviewed for self-determination.</p> <p>The facility failed to allow Resident #1 to go on activity outings with his peers, only allowing him to utilize an outside vendor, which caused him to feel angry and viewed as less important as his peers because of his disability.</p> <p>This failure placed residents at risk for being denied the opportunity to exercise their autonomy regarding things that were important in their lives and a decrease in their quality of life.</p> <p>Findings included:</p> <p>Record review of Resident 1's EHR revealed a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included dementia (defective memory), mild cognitive impairment (memory and/or thinking problems), acquired absence of left and right leg above the knee, and chronic pain. Resident #1 was noted to be his own RP.</p> <p>Record review of Resident #1's Annual MDS assessment dated [DATE] revealed Resident #1's BIMS was not assessed. Section F interview for activity preferences included Resident #1 answered a question, replying it was very important that he did things with groups of people and that he did his favorite activities.</p> <p>Record review of the care plan last revised on 11/25/24 for Resident #1 reflected the following areas of focus: psychosocial wellbeing r/t the lack of family and friend visitation, and effectively cope with his feelings of isolation and loneliness. There was an intervention to, Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility.</p> <p>Record review of Resident #1's Progress Notes reflected an entry dated 12/6/24, by the SW, which indicated Resident #1 had answered all the BIMs questions correctly, indicating Resident #1's cognition was intact.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/6/24 at 11:19 am with a resident of the facility who asked not to be identified for fear of retaliation, revealed concerns regarding a friend who also lived at this facility. This resident felt Resident #1 was not being treated fairly as he was no longer permitted to go with the rest of them on outings because he was a double amputee. The resident stated staff have told them it was because of something that happened at another facility.</p> <p>In an interview on 12/6/24 at 11:28 am Resident #1 stated his main concern was that he had been, discriminated against because of my disability. He stated he had been at the facility for years and all the sudden months ago, they told him he could not ride in the facility van because he was a double amputee. Resident #1 stated it was him watching his friends leave and go to the store without him, like I am some kind of loser. He was told it was now a policy because of something that happened at another facility when a double amputee got hurt and was now suing. Resident #1 stated he was mad because, we are not all the same person just because we are double amputees. He stated he cannot spend that time with his friends, it was fun and there was not a whole lot of fun available to him these days. Resident #1 stated Now they (the facility staff) say it is for my safety they know I'm mad I have let everyone know. In an additional interview at 12:30 pm with Resident #1, he stated he does know that he can take a hired van that is not the facility's. He asked, how is that supposed to make me feel? I am the only one here that is not allowed. He stated he just has not gone on outings since they started this new rule.</p> <p>In an interview on 12/6/24 at 2:02 pm with CNA A he stated Resident #1 has complained to him about not being allowed on the company van. CNA A stated if there was an outing, they would make sure he has a ride with a transportation company, but there was a policy that he cannot ride in the facility van. CNA A said it was for Resident #1' own safety. He stated he was not sure, but he thought that something had happened at another facility which caused the change in policy .</p> <p>In an interview on 12/6/24 at 2:35 pm, CNA B stated she was not sure how long ago it was when they started saying Resident #1 could not ride in the facility van, but she thought it was a few months ago. She stated she was told Resident #1 could not ride because it was a safety issue. She stated that he could not be protected by the seatbelt in the van and, that the new policy was to protect the resident. CNA B stated they would provide a safe ride with another transportation company .</p> <p>In an interview on 12/6/24 at 2:49 pm with ADON C he stated Resident #1 had not expressed any concern to him about the van policy. ADON C stated he was aware that Resident #1 was not supposed to ride in the facility van, but they could call a transportation service .</p> <p>In an interview on 12/6/24 at 3:01 pm with LVN D, she stated Resident #1 had not spoken to her about his concerns regarding not being allowed to ride in the facility van. LVN D stated the policy said he could not ride because it was a safety risk for someone that did not have at least one leg to balance themselves.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/6/24 at 4 :22 pm with the facility SW revealed she had worked at the facility for about 10 months and during that time Resident #1 had refused to do a BIMS assessment and stated the questions were stupid. The SW stated she asked today and told him the interviewer was asking what the results of a BIMS assessment were, so he agreed to answer the questions. She stated he answered all the questions correctly. The SW stated she knew Resident #1 was unhappy about not going on the trips to the local retail store, but that it was his choice. She stated she thought the facility would arrange transportation for him with the transport company, but he had refused to utilize the alternate transportation. She stated she went to the store for him every Friday and purchased the items he requested .</p> <p>In an interview on 12/06/24 at 12:00 pm, 3:10 pm, and 5:10 pm with the facility Adm, she stated Resident #1 was not allowed to ride in the facility van. She stated they could not ensure the safety of a double amputee. The Adm stated they had talked with Resident #1 about providing alternate transportation with a contracted medical transport company. The Adm stated she was not aware of any difference with how transportation was accomplished using the transport company, other than they (the facility) had a policy saying they could not transport the resident and the medical transport service would transport him. The Adm stated she did consider the policy to be for the protection of the resident and not for the facility's protection. In a continued interview at 3:10 pm, the Adm stated that their residents did not socialize on the van during trips. She stated the facility van manufacturer told the facility the seatbelts in the van were not adequate for a double amputee. Continued and final interview at 5:10 pm, prior to the exit, the Adm stated there was not a specific sentence in the policy that read double amputees were not allowed on the van, but she had highlighted in the policy a section that read about the facility ensuring the residents' safety .</p> <p>In an interview on 12/09/24 at 11:45 am with a driver/worker at the alternate transportation company used by the facility, she stated they used a normal van for transportation. They did not have special procedures or equipment for a person that was a double amputee.</p> <p>Record review of the facility's policy, last updated 8/2024 (with no date of the month noted) and entitled, Driver and Vehicle Safety Policy, with the subject highlighted Resident Wheelchairs in transportation revealed: Geri-chairs and scooters may NOT be used for transportation in the company vehicle. Wheelchairs, including tilt wheelchairs, used for transportation should meet current ANSI and Society of Automotive Engineers (SAE) standards for wheelchairs used in motor vehicles. Wheelchairs should have a frame which has four securement points for tie down straps and can withstand an impact or accident. Motorized wheelchairs may be used for transport; they should be turned off before loading the wheelchair into the lift or van, and should remain off for the entire trip, until the wheelchair has been completely unloaded from the van.</p> <p>Continued review revealed the 35-page policy did not contain any documentation about van use restrictions for residents with double amputations.</p> <p>Record review of the facility's policy, updated 2/2021 and entitled, Resident Rights, with the policy statement: Employees shall treat all residents with kindness, respect, and dignity. Policy interpretation and implementation includes,</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to:</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. a dignified existence;</p> <p>b. be treated with respect, kindness, and dignity;</p> <p>c. be free from abuse, neglect, misappropriation of property, and exploitation;</p> <p>d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms;</p> <p>e. self-determination</p> <p>On 12/6/2024, the facility failed to provide documentation of the van manufacturer's report to the facility that the van seatbelt was not adequate for a double amputate when this documentation was requested.</p>		