STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675596	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Valley Rehabilitation and Healthcare Cente	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on , interviews, and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #3) of 4 residents reviewed for quality of care. The facility failed to provide wound care for Resident #1 in accordance with physician orders (three times a week on 11/27/2025, 11/29/2025 and 12/4/2025) and daily (12/10/2025, 12/11/2025 and 12/12/2025). The facility failed to change Resident #1's dressing when it appeared soiled according to physician's orders on 12/2/2025 and 12/11/2025 according to Resident #1's November 2025 and December 2025 TAR. This deficient practice could place residents at risk for not being provided the care/treatment required, and/or delayed treatment. Findings included: Review of Resident #1's face sheet reflected an [AGE] year-old male admitted on [DATE] and discharged on 12/20/2025 with diagnoses of unspecified systolic heart failure (heart does not contract forcefully to meet the body's need), personal history of poliomyelitis (viral disease that attacks central nervous system potentially leading to paralysis), cognitive communication deficit (difficulty speaking, listening, reading or writing caused by problems with thinking skills, memory and attention), dysphagia (difficulty swallowing), vascular dementia (occurs when damaged blood vessels reduce blood flow and oxygen to the brain impairing thinking, memory and behaviors), and peripheral vascular disease (circulation disorder where narrowed blood vessels reduce blood flow). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 13which indicated no cognitive impairment. Review reflected Resident #1 was at risk of developing pressure ulcers. Review reflected Resident #1 had 5 venous and arterial ulcers (caused by poor blood flow from narrowed arteries creating punched-out wounds) and included infection of the foot and other open lesions on the foot. Review of hospital discharge wound care orders dated 11/24/2025 reflected wound care instructions for bilateral lower extremity to clean wounds with saline and gauze, remove crusts, dress wounds with hydrofera blue foam, secure with kerlix and ace wrap and change twice weekly and prn. Review of Resident #1's physician orders dated 11/24/2025 reflected bilateral lower extremity and clean wounds with saline and gauze, remove crusts, dress wounds with hydrofera blue foam, secure with kerlix and ace wrap and to change twice weekly and prn and indicated every 72 hours for wound care. Review of Resident #1's physician orders dated 12/04/2025 reflected bilateral lower extremity and clean wounds with saline and gauze, remove crusts, dress wounds with xeroform (sterile mesh gauze dressing with treatment to fight bacteria), secure with kerlix and ace wrap, change twice weekly and prn every day shift every Tuesday and Friday. Review of wound assessment report by wound care NP dated 11/25/2025 reflected treatment as three times per week and PRN, cleanse with wound cleanser, xeroform, with ABD (abdominal pad) and kerlix as dressings for bilateral extremities. Review reflected exudate amount (how much fluid saturates the dressing) as heavy. Review of Resident #1's November 2025 TAR dated 11/24/2025 and discontinued on 12/04/2025 reflected bilateral lower extremity and clean wounds with saline and gauze, remove crusts, dress wounds with hydrofera blue foam(antibacterial wound dressing), secure with kerlix (gauze bandage) and ace wrap and to change twice weekly and prn and indicated every 72 hours for wound care. Review reflected wound care was performed on 11/25/2025. Review reflected Resident #1 refused wound care on 11/28/2025 and not performed. Review of wound assessment report by wound care NP dated 11/25/2025 reflected treatment as three times per week and PRN, cleanse with wound cleanser, xeroform(sterile mesh gauze dressing with treatment to fight bacteria), with ABD (abdominal pad) and kerlix as dressings for bilateral extremities. Review reflected exudate amount (how much fluid saturates the dressing) as heavy. Review of Resident #1's December 2025 TAR dated 11/24/2025 and discontinued 12/04/2025 reflected bilateral lower extremity and clean wounds with saline and gauze, remove crusts, dress wounds with hydrofera blue foam, secure with kerlix and ace wrap and to change twice weekly and prn and indicated every 72 hours for wound care. Review reflected Resident #1 refused wound care on 12/02/2025. Review reflected new order dated 12/04/2025 and discontinued 12/28/2025 for bilateral lower extremity, to clean wounds with saline and gauze, remove crusts, dress wounds with xeroform, secure with kerlix and ace wrap, change twice weekly and PRN every day shift every Tuesday and Friday. Review reflected wound care was performed on 12/05/2025 and 12/09/2025. Wound care was not performed on 12/04/2025 or 12/06/2025. Review reflected wound care was not provided on 12/10/2025, 12/11/2025 or 12/12/2025. Review of November 2025 and December 2025 MAR/TAR reflected no PRN wound care was completed. Review of Resident #1 progress notes reflected no

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, maintaining medical records on each resident that are complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for clinical records. The facility failed to document that Resident #1 had a care plan conference on 12/4/2025. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records.Findings include: Review of Resident #1's face sheet reflected an [AGE] year-old man admitted on [DATE] and discharged on 12/20/2025 with diagnoses of unspecified systolic heart failure (heart does not contract forcefully to meet the body's need), personal history of poliomyelitis (viral disease that attacks central nervous system potentially leading to paralysis), cognitive communication deficit (difficulty speaking, listening, reading or writing caused by problems with thinking skills, memory and attention), dysphagia (difficulty swallowing), vascular dementia (occurs when damaged blood vessels reduce blood flow and oxygen to the brain impairing thinking, memory and behaviors), and peripheral vascular disease (circulation disorder where narrowed blood vessels reduce blood flow). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 13 which indicated no cognitive impairment. Review reflected Resident #1 was at risk of developing pressure ulcers. Review reflected Resident #1 had 5 venous and arterial ulcers (caused by poor blood flow from narrowed arteries creating punched-out wounds) and included infection of the foot and other open lesions on the foot. Review of Resident #1's baseline care plan reflected a date of 11/25/2025 and no discharge plans. Review of care conference note dated 11/26/2025 reflected an admission / baseline care plan conference was held on 11/26/2025 with Resident #1's RP via phone. Review reflected Resident #1's conditions were reviewed at admission and present conditioners were barriers to wound healing were reviewed. The care conference note was signed by MDS F. Review of Resident #1's progress notes reflected there was no care plan conference meeting documented for 12/04/2025. Review of Resident #1's assessments reflected there was no care plan conference meeting documented for 12/04/2025. During an interview on 01/02/2026 at 11:08 AM, LMSW stated a few care plan conference were held for Resident #1. LMSW stated there were at least 2 or 3. LMSW stated that MDS nurse was supposed to put in a note for the care plan conference and she did not put it in. LMSW stated that MDS nurse was no longer at the facility. LMSW stated there was a care plan meeting held on 12/04/2025 at 2:00 PM and LVN A, and DOR were present. LMSW stated that the nurse was responsible to put in care plan conference notes because it was a lot of medical questions. LMSW stated she sometimes had to remind the nurse. LMSW stated it was important that the note be put in each time and to document any concerns that were discussed. LMSW stated she reviewed the note was put in at least once every three more, but sometimes more frequently. LMSW stated what is the point of having the meeting if it's not going to be documented During an interview on 01/02/2026 at 11:26 AM, DOR stated he participated in the care plan conference on 12/04/2025. During an interview on 01/02/2026 at 11:42 AM, ADON stated that documentation of care plan meetings was supposed to be done by the MDS nurse or LMSW. ADON stated it was important to document meetings for the records. During an interview on 01/02/2026 at 1:07 PM, MDS F stated she has worked at the facility for about 2 months. MDS F stated she was in training until about 2 weeks ago. MDS F stated during a care plan conference each section in the note is put in by the respective discipline, but sometimes she had to fill in other departments' parts. MDS F stated she participated in a care plan conference for Resident #1 when he first admitted but not any other meetings. MDS F stated she thought there were more meetings but that those were not actual care plan meetings. MDS F stated what determined if a meeting was an actual care plan meeting was if there was an emergency circumstance or if something needed to be addressed. MDS F stated if there was a meeting it should have been documented at least in a progress note. During an interview on 01/02/2026 at 1:25 PM, the DON stated LMSW should document that the meeting occurred and who was present. The DON stated she hoped documentation was completed within a few days. The DON stated any care plan meeting should be documented even if it was brief note with concerns discussed. During an interview on 01/02/2026 at 1:56 PM, the ADM stated she knew there was a care plan meeting held on 12/04/2025 because Resident #1's RP came in to do admission paperwork that day. The ADM stated that she expected if any care plan is held there would be some kind of note. The ADM stated she expected MDS F or a nurse to document the note or LMSW should document. The ADM stated it was important to