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	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Valley Rehabilitation and Healthcare Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for1 (Resident #1) of 1 reviewed for abuse and neglect. On 01/03/26, Resident #1 fell out of bed after the bed brakes/wheel locks were not set. Resident #1 sustained no injuries, but was sent to the ER. The facility failed to thoroughly investigate this incident, as well as failed to submit the investigation to the state agency. This deficient practice placed residents at risk of ongoing neglect due to not having a thorough investigation done for facility reported incidents.Record review of Resident #1's Care Plan dated 01/04/26 revealed a [AGE] year-old male who was admitted to the facility 03/01/22 and diagnosed with Other Seizures (temporary surge of uncontrolled activity in the brain/unspecified type), Insomnia (a sleep disorder), Obstructive Sleep Apnea (a sleep disorder), Epilepsy (a brain disorder causing recurrent seizures), Intractable w/Status Epilepticus (severe, prolonged seizure), Intellectual Disabilities (learns, things and develops slowly), Generalized Anxiety Disorder (extreme worry), Schizoaffective Disorder Bipolar Type (mental health condition blending symptoms of schizophrenia [hallucinations, delusions] and mood disorder [mania depression]), Persistent Mood Disorder (long-term, low-grade depression), Personality Disorder (a mental health disorder), , Acquired Absence of Right Leg Above Knee, Peripheral Vascular Disease (poor blood flow to limbs), Muscle Wasting (shrinking, weakening, loss) and Atrophy shrinking of tissue) Right/Left Upper Arm, Cognitive Communication Deficit and (a speech problem). Additional record review of Care Plan reflected, Keep bed in lowest position with wheels locked. Focus: Resident s a behavior problem of self-adjusting the [NAME] of his bed and keeps his bed in a high position. Interventions: Encourage/redirect Resident #1 to keep bed in low position as needed. Record review of facility incident report dated 01/03/26 reflected Resident #1 had a fall w/o injury. The report failed to include information related to an investigation of neglect, or notification to HHSC. Record review of ER Provider Note dated 01/03/26 reflected, Vitals of normal range; Exam: Constitutional - alert and oriented and responds appropriately to questions, well-appearing; well-nourished. CARD: Tachycardia. RESP: no respiratory distress. ABD/GI: non-distended. EXT: Tenderness to palpation of the left hip and left femur. SKIN: Normal color for age and race, warm, dry good turgor, no acute lesions noted. NEURO: Moves all extremities equally. PSYCH: Intermittently agitated. Re-Evaluation: (Resident #1) apparently prefers to sleep on his left side. He was rolling in the bed and rolled too far causing him to fall off the bed and landed onto his left side. Per EMS, (Resident #1) complaining of left hip pain since the fall. Otherwise at his baseline mentation per the nursing home. On attempts to assess (Resident #1), (Resident #1) continuously yelling: do not touch me, it hurts: multiple attempts made to try and understand what is hurting. (Resident #1) states his back and his hip is hurting. We will proceed with imaging including CT imaging of the back. (Resident #1) otherwise (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

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is hemodynamically stable at this time. We will also obtain head if (Resident #1) if (Resident #1) hit his head or not. UA is negative. Chest x-ray w/o any signs of infection. (Resident #1) at this time remains asymptomatic. He has family at base bedside who stated that he is at his baseline mentation. They are comfortable with the plan for discharge back to his facility. IMPRESSION: No acute abnormality. CT Brain: No acute intracranial abnormality. CT Cervical Spine: No acute fracture or traumatic malalignment. (Resident #1) reports pain after (pain medication). Imaging was without Any acute findings. Still is intermittently agitated on examination and yells that he is cold. Record review of Hospital Discharge Record dated 01/03/26 reflected, You were seen today for: fall. Patient instructions reviewed: Fall Prevention received 01/04/26. Activity Restrictions or Additional Instructions: Please follow up with the primary care for further evaluation. Return to the emergency department for any new or worsening symptoms. Follow-up Please contact the following to make an appointment for follow-up care: *Your Primary Care Physician Follow-up Plan: 1-2 Days Note: Your health care plan may require a referral from your primary care provider prior to making an appointment. Observation and interview on 01/20/26 at 11:45 AM revealed Resident #1 lying in a bed against the wall, closest to his left side. He had no visible marks/bruises. The bed wheels were locked, and the bed was unable to be moved. Resident #1 stated two white nurses failed to lock his bed wheels and he fell as a result. He stated he had pain from the fall but no longer had any pain from the fall. In an interview on 01/20/26 at 10:25 AM, the LG for Resident #1 stated Resident #1 had a fall due to Resident's bed wheels not being locked. She stated he was morbidly obese and an amputee. She stated he was fully dependent on the bed to be in place. She added he leaned on the wall for his best comfort. She stated he was bedfast and was at least a 2-person assist for transfer. She stated his amputation was on the right leg. She stated she was made aware of the information because she was his legal guardian. She stated he scraped his elbow during the fall and was complaining of pain. She stated nothing like this had occurred in the past. She stated date of fall was 01/03/26 at unknown time. She stated he had been to the hospital as a result of this but was not aware of any resulting injuries. In an interview with CNA C on 01/20/26 at 12:36 PM, she stated she ad been with the facility 3 years, and she worked hall A (Resident #1's hall). She stated beds always had to be locked. She stated the day of the incident, she was not at work, and added CNAs A and B worked with Resident #1 that evening. In an interview with the LVN on 01/20/26 at 01:45 PM, she stated the wheels on Resident #1's bed were not locked at the time of his fall. She stated she did not know if there was a policy related to locking bed wheels. She stated nurse aides were trained to unlock and re-lock bed wheels when they finished tasks. The LVN stated she was not working the day of the incident; however, staff have been in-serviced on that topic. She stated no incident of that nature had occurred since her start date of May 2025. She stated she was not sure which aides were involved. She stated risk for leaving resident beds unlocked included a resident falling out of the bed. She stated staff were usually really good at locking the wheels. The LVN stated Resident #1 was not injured when he fell. She stated she knew wheels were unlocked because the information was in the incident report. The LVN stated the charge nurse was responsible for ensuring aides completed tasks, and added ultimately, she was over the charge nurse. She stated Resident #1 saw the NP after ER visit. She stated on the 3rd, staff who worked with Resident #1 was CNA A, and added she was the only staff member assigned to his hall that day. The LVN stated other staff would have come and assisted her. In an interview with CNA A on 01/20/26 at 02:00 PM, he stated recent in-service training covered ANE, resident transfers and bed locks. CNA A stated the day of the incident, he was working a different hall. He stated he came to assist CNA B. CNA A stated when he arrived in the room, Resident #1 was on the floor, uninjured. CNA A stated CNA C (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worked 1st shift the day of the fall. In a telephone interview with CNA B on 01/20/26 at 02:13 PM, she stated she worked the day of 01/03/26 and responded to Resident #1 after he fell. She stated Resident #1 tended to lean left. CNA B stated she did not normally work that hall, but did that day. She stated she was helping another resident when the incident occurred. She stated her training on resident falls included gait belts, transfers and bed locks. She stated this type of incident had not occurred before. CNA B stated Resident #1 had a fall mat on the side of the bed but not against the wall. She stated when she came in that day, Resident #1 had already been cleaned up. She stated the wound care nurse and EMS said not to touch Resident #1. In an interview with the ADM on 01/20/26 at 02:20 PM, she stated no staff were written up or disciplined about the incident in which Resident #1 fell off his bed on 01/03/26, because she was unable to determine who had been responsible for failing to lock his bed wheels. She stated she in-serviced the staff on locking bed wheels and Resident #1 was sent to the ER to ensure he had no injuries. She stated he returned from the ER and had no injuries, so the incident was not reported to HHSC. She stated there was no facility policy related to bed wheels being locked. Record review of Abuse Prohibition policy dated 06/02/25 reflected, Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. 2. The facility will conduct an investigation of alleged or suspected abuse, neglect, or misappropriation of property, and will provide notification of information to the proper authorities according to state and federal regulations. Record review of in-services dated 01/03/26 with the notation: Bed Brakes need to be locked at all times. If providing care brakes need to be relocked.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that 1 (Resident #1) of 1 residents received adequate supervision that could prevent accidents when reviewed for supervision. On 01/03/26, Resident #1 fell out of bed and was found on the floor, uninjured, when his bed brakes were not locked. These failures placed residents at risk of accidents and injuries. Record review of Resident #1's Care Plan dated 01/04/26 revealed a [AGE] year-old male who was admitted to the facility 03/01/22 and diagnosed with Other Seizures (temporary surge of uncontrolled activity in the brain/unspecified type), Insomnia (a sleep disorder), Obstructive Sleep Apnea (a sleep disorder), Epilepsy (a brain disorder causing recurrent seizures), Intractable w/Status Epilepticus (severe, prolonged seizure), Intellectual Disabilities (learns, things and develops slowly), Generalized Anxiety Disorder (extreme worry), Schizoaffective Disorder Bipolar Type (mental health condition blending symptoms of schizophrenia [hallucinations, delusions] and mood disorder [mania depression]), Persistent Mood Disorder (long-term, low-grade depression), Personality Disorder (a mental health disorder), , Acquired Absence of Right Leg Above Knee, Peripheral Vascular Disease (poor blood flow to limbs), Muscle Wasting (shrinking, weakening, loss) and Atrophy shrinking of tissue) Right/Left Upper Arm, Cognitive Communication Deficit and (a speech problem). Additional record review of Care Plan reflected, Keep bed in lowest position with wheels locked. Focus: Resident has a behavior problem of self-adjusting the height of his bed and keeps his bed in a high position. Interventions: Encourage/redirect Resident #1 to keep bed in low position as needed. Focus: Resident #1 has had an actual fall. Goal: Resident #1 will have no injuries related to falls through the review date. Intervention/Tasks: (Resident #1) sent out to ER for eval and treat post fall. Upon return, no injuries per ER, neuros were initiated. Record review of Resident #1's MDS dated [DATE] reflected:*BIMS score of 05*Intellectual disability*Mobility device: wheelchair*Transfer status of 2 or more people Record review of facility incident report dated 01/03/26 reflected Resident #1 had a fall w/o injury. Record review of ER Provider Note dated 01/03/26 reflected, Vitals of normal range; Exam: Constitutional - alert and oriented and responds appropriately to questions, well-appearing; well-nourished. CARD: Tachycardia. RESP: no respiratory distress. ABD/GI: non-distended. EXT: Tenderness to palpation of the left hip and left femur. SKIN: Normal color for age and race, warm, dry good turgor, no acute lesions noted. NEURO: Moves all extremities equally. PSYCH: Intermittently agitated. Re-Evaluation: (Resident #1) apparently prefers to sleep on his left side. He was rolling in the bed and rolled too far causing him to fall off the bed and landed onto his left side. Per EMS, (Resident #1) complaining of left hip pain since the fall. Otherwise at his baseline mentation per the nursing home. On attempts to assess (Resident #1), (Resident #1) continuously yelling: do not touch me, it hurts: multiple attempts made to try and understand what is hurting. (Resident #1) states his back and his hip is hurting. We will proceed with imaging including CT imaging of the back. (Resident #1) otherwise is hemodynamically stable at this time. We will also obtain head if (Resident #1) if (Resident #1) hit his head or not. UA is negative. Chest x-ray w/o any signs of infection. (Resident #1) at this time remains asymptomatic. He has family at base bedside who stated that he is at his baseline mentation. They are comfortable with the plan for discharge back to his facility. IMPRESSION: No acute abnormality. CT Brain: No acute intracranial abnormality. CT Cervical Spine: No acute fracture or traumatic malalignment. (Resident #1) reports pain after (pain medication). Imaging was without Any acute findings. Still is intermittently agitated on examination and yells that he is cold. Record review of Hospital Discharge Record dated 01/03/26 reflected, You were seen today for: fall. Patient instructions reviewed: Fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevention received 01/04/26. Activity Restrictions or Additional Instructions: Please follow up with the primary care for further evaluation. Return to the emergency department for any new or worsening symptoms. Follow-up Please contact the following to make an appointment for follow-up care: *Your Primary Care Physician Follow-up Plan: 1-2 Days Note: Your health care plan may require a referral from your primary care provider prior to making an appointment. Observation and interview on 01/20/26 at 11:45 AM revealed Resident #1 lying in a bed against the wall, closest to his left side. He had no visible marks/bruises. The bed wheels were locked, and the bed was unable to be moved. Resident #1 stated two white nurses failed to lock his bed wheels and he fell as a result. He stated he had pain from the fall but no longer had any pain from the fall. In an interview on 01/20/26 at 10:25 AM, the LG for Resident #1 stated Resident #1 had a fall due to Resident's bed wheels not being locked. She stated he was morbidly obese and an amputee. She stated he was fully dependent on the bed to be in place. She added he leaned on the wall for his best comfort. She stated he was bedfast and was at least a 2-person assist for transfer. She stated his amputation was on the right leg. She stated she was made aware of the information because she was his legal guardian. She stated he scraped his elbow during the fall and was complaining of pain. She stated nothing like this had occurred in the past. She stated date of fall was 01/03/26 at unknown time. She stated he had been to the hospital as a result of this but was not aware of any resulting injuries. In an interview with the LVN on 01/20/26 at 01:45 PM, she stated the wheels on Resident #1's bed were not locked at the time of his fall. She stated she did not know if there was a policy related to locking bed wheels. She stated nurse aides were trained to unlock and re-lock bed wheels when they finished tasks. The LVN stated she was not working the day of the incident; however, staff have been in-serviced on that topic. She stated no incident of that nature had occurred since her start date of May 2025. She stated she was not sure which aides were involved. She stated risk for leaving resident beds unlocked included a resident falling out of the bed. She stated staff were usually really good at locking the wheels. The LVN stated Resident #1 was not injured when he fell. She stated she knew wheels were unlocked because the information was in the incident report. The LVN stated the charge nurse was responsible for ensuring aides completed tasks, and added ultimately, she was over the charge nurse. She stated Resident #1 saw the NP after ER visit. She stated on the 3rd, staff who worked with Resident #1 was CNA A, and added she was the only staff member assigned to his hall that day. The LVN stated other staff would have come and assisted her. In an interview with CNA A on 01/20/26 at 02:00 PM, he stated recent in-service training covered ANE, resident transfers and bed locks. CNA A stated the day of the incident, he was working a different hall. He stated he came to assist CNA B. CNA A stated when he arrived in the room, Resident #1 was on the floor, uninjured. CNA A stated CNA C worked 1st shift the day of the fall. In a telephone interview with CNA B on 01/20/26 at 02:13 PM, she stated she worked the day of 01/03/26 and responded to Resident #1 after he fell. She stated Resident #1 tended to lean left. CNA B stated she did not normally work that hall, but did that day. She stated she was helping another resident when the incident occurred. She stated her training on resident falls included gait belts, transfers and bed locks. She stated this type of incident had not occurred before. CNA B stated Resident #1 had a fall mat on the side of the bed but not against the wall. She stated when she came in that day, Resident #1 had already been cleaned up. She stated the wound care nurse and EMS said not to touch Resident #1. In an interview with the ADM on 01/20/26 at 02:20 PM, she stated no staff were written up or disciplined about the incident in which Resident #1 fell off his bed on 01/03/26, because she was unable to determine who had been responsible for failing to lock his bed wheels. She stated she in-serviced the staff on locking bed wheels and Resident #1 was sent to the ER to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure he had no injuries. She stated he returned from the ER and had no injuries, so the incident was not reported to HHSC. She stated there was no facility policy related to bed wheels being locked. Record review of in-services dated 01/03/26 with the notation: Bed Brakes need to be locked at all times. If providing care brakes need to be relocked.