STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675649	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 8 residents (Resident #16 reviewed for pain.The facility failed to ensure Resident #16 received pain management to the fullest extent possible, resulting in her experiencing pain on 04/22/2026. This failure placed residents at risk of uncontrolled pain. Findings included:Record review of the undated face sheet for Resident #16 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cancer of both lungs, brain cancer secondary to lung cancer, chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), generalized anxiety disorder, and pain.Record review of the quarterly MDS assessment for Resident #16 dated 03/04/2026 reflected a BIMS score of 07, indicating severe cognitive impairment. It reflected that she had experienced pain frequently and pain had made it difficult for her to sleep over the previous five days. It reflected pain had occasionally interfered with her activities during the day. It reflected that she received both scheduled and PRN pain medications over the previous five days.Record review of the care plan for Resident #16 dated 02/06/2026 reflected the following: FOCUSThe resident has PRN pain medication therapy r/t cancer of lung and brain.GOALThe resident will be free of any discomfort or adverse side effects from pain medication through the review date.INTERVENTIONS:Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.Review per facility protocol for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; Controlled when therapeutic regimen followed, but not always followed as ordered; Therapeutic regimen followed, but pain control not adequate, changes required.Record review of physician orders for Resident #16 reflected the following orders:-FentaNYL Patch 72 Hour 100 MCG/HR Apply 2 patch transdermally every 72 hours for pain apply 2 patchesof 100 mcg to = 200 mcg; total dose 200 mcg; remove old patch first and remove per schedule dated 01/25/2026-oxyCODONE HCl Oral Tablet 20 MG (Oxycodone HCl) Give 1 tablet by mouth every 2 hours as needed for pain dated 08/25/2025-MONITOR FOR PAIN EVERY SHIFT USE 0-10 SCALE (A) FOR ALERT RESIDENTS USE PAIN AD (B) FOR CONFUSED RESIDENTS DOCUMENT WHICH PAIN SCALE USED TO ASSESS RESIDENTS PAIN RATING. every shift dated 08/05/2025.Record review of the pain assessment tool on Resident #16's April 2026 treatment administration record reflected a pain level of 0 (indicating no pain) on all three shifts (day, evening, night) for 04/21/2026 and a 9 (indicating severe pain) on the day and evening shifts for 04/22/2026. Record review of the April 2026 medication administration record for Resident #16 reflected that she received a Fentanyl patch on 04/19/2026 at 1:51 PM and again on 04/22/2026 at 11:59 AM. It reflected that she received PRN administrations of oxycodone with a pain scale of 4 reported (indicating mild pain) on 04/21/2026 at 8:17 PM and another with a pain scale of 9 reported (indicating severe pain) at 9:51 AM the following morning.Observation on 04/21/2026 at 9:04 AM, (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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F 0697 Level of Harm - Actual harm Residents Affected - Few	11:08 AM, and 2:53 PM revealed Resident #16 sat in the doorway of her room and told any staff who walked by that she was in pain and needed medication. She touched her chest and said that was where she hurt and that she also had a very bad headache. At 9:04 and 11:08 AM, LVN D responded to her immediately. At 02:53 PM, RN A was already standing near to her and responded to her. (These observations correlate with PRN administrations of oxycodone listed above.) Observation at 3:00 PM revealed CNA J pulled back Resident #16's shirt to reveal a fentanyl patch on her back dated 04/19/2026. Observation on 04/22/2026 at 7:12 AM revealed Resident #16 was in her wheelchair at her door saying she needed help and was in pain. She was not wincing, grimacing, red-faced, or sweating, but she did appear anxious. She called out to anyone she saw on the hall, and CNA J responded to her and took her into the bathroom and then back out again after a few minutes. There was no nurse observed on the hall at this time. Resident #16 sat in her wheelchair in her doorway for the next hour and a half, occasionally asking for help. CNA J responded to her requests each time and assisted her to the bathroom once. The ADON was observed entering the hall at 08:15 AM with a medication cart and began working her way up the hall passing medications to residents in each room. During an interview on 04/22/2026 at 7:18 AM, Resident #16 stated she was in a lot of pain in her chest. She stated she had cancer in her lungs which had spread to her brain, and she hurt mostly in her chest but also had a headache. She stated she did not know when the last time she had a pain pill was, but she wanted one. During an interview on 04/22/2026 at 10:00 AM on the hall just outside Resident #16's room, the ADON stated she was working the floor that day, because the nurse who had been scheduled did not show up for the shift. She stated Resident #16 was on Hospice, and the IDT was responsible for reviewing pain assessments and PRN administration so that the Hospice physician could determine if a change in orders was warranted. She stated she knew Resident #16 to frequently complain of pain and that Resident #16 had a diagnosis of lung and brain cancer that was likely to cause pain. She looked at the pain assessment tool on the medication cart computer and stated she could see that the zeros on the pain assessment may not have properly reflected the pain that resident was experiencing. She stated she also noticed that she had documented Resident #16's pain at a 9 that morning, and there had been no administration of PRN pain medication all night. The ADON stated she had just administered a PRN oxycodone to Resident #16 and was waiting to complete the follow up evaluation to ensure it was effective. She stated it made sense that Resident #16's pain level might not have gotten all the way to a 9 if she had received earlier PRN administrations of oxycodone. She stated she could see that Resident #16 was not receiving pain medication as often as she might need it to stay on top of her pain.During an interview on 04/23/2026 at 2:20 PM, CNA J stated she worked both the daytime and evening shifts on the hall where Resident #16 lived. She stated part of providing care was asking if residents were in any kind of pain. She stated Resident #16 had frequent pain, and she always reported the pain to the nurse. She stated she had no idea when pain medications were administered and could not access that information on the EMR. She stated there were many things that helped distract Resident #16 from her pain such as snacks and visitors, but she said she was in pain nearly every time she was asked. During an interview on 04/23/2026 at 3:27 PM, the MD stated she talked with Resident #16 every time she visited the facility, which was once per month. She stated that when considering whether Resident #16 needed more pain medication available in her orders, she looked at how frequently the medication was administered PRN. She stated she did not usually look at the pain assessment tool, because the pain assessment also had to be conducted when a PRN oxycodone was administered. She stated if pain was being underreported on the pain assessment tool, it might not give an accurate reflection of Resident #16's need for pain control. During an interview on 04/23/2026 at 3:48 PM, the DON stated they had asked Hospice to review Resident #16's chart in January and had increased the dosage of her Fentanyl patch and felt it might have been time to ask them to come back and review the pain control. She stated Resident #16 would come and ask for pain medication, so they had felt sure she would be getting as much pain medication as she needed. She stated she did not consider that the (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	nursing staff might be too busy to assess Resident #16 as often as she needed it assessed to prevent pain from breaking through. The DON stated she ensured that resident pain was controlled by interviewing residents, reviewing medications, and reviewing the frequency residents requested PRN pain medication so she could notify the doctor if it became especially frequent. She stated the potential negative outcome of underutilizing a PRN pain medication was the resident would not feel well and would not have good quality of life. During an interview on 04/23/2026 at 4:22 PM, the ADM stated the floor nurses were responsible for assessing and treating pain in residents who experienced pain. She stated oversight of the pain management system in the facility was the responsibility of nursing administration (ADON, DON). She stated she monitored for compliance through morning meetings and talking with the nurse administration. She stated a potential negative outcome of a failure to control a resident's pain would be increased pain. Record review of facility policy dated October 2022 titled Pain- Clinical Protocol reflected the following: Assessment and recognition1. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity.a. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.2. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning.3. The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls.4. The nursing staff will identify and document residents with a history of opiate use disorder and those who are currently receiving medication assisted treatment for opiate dependence (e.g., methadone, buprenorphine, buprenorphine/naloxone, naltrexone).MonitoringThe staff will assess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain.5. The staff will evaluate and report the resident/patient's use of standing and PRN analgesics.a. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain.b. If there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 3 residents (Resident #36) reviewed for medication errors. 1. The facility failed to administer the correct dosage of medication to Resident #36 on 04/22/26. 2. The facility failed to administer the medication to Resident #36 at the time ordered by Physician 04/22/26. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization. Findings included: Record review of Resident #36's undated face sheet reflected a [AGE] year-old female with an initial admission date 12/07/2018. Resident #36 had diagnoses that included Alzheimer's disease unspecified (a progressive neurodegenerative disorder causing dementia, with symptoms including memory loss, cognitive decline, and behavioral changes), anxiety disorder (serious mental health conditions characterized by persistent, excessive fear or worry that interferes with daily life, going beyond temporary stress), unspecified bipolar disorder, current episode mixed, moderate (manic and depressive symptoms occur simultaneously or in rapid succession), dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance (^cognitive impairment caused by underlying conditions^^cognitive impairment caused by underlying conditions), history of fallings, and psychophysiologic insomnia (chronic sleep disorder characterized by learned sleeplessness, where anxiety about falling asleep, often tied to the bedroom environment, causes heightened arousal). Record review of Resident #36's annual comprehensive MDS, dated [DATE] reflected a BIMS score of 00 which indicated severe cognitive impairment. Record review of Resident #36's undated care plan reflected an ADL self-care performance deficit r/t generalized deconditioning, weakness, cognitive impairment, has impaired cognitive function/impaired thought processes r/t changes occurring with progression of Alzheimer's disease. Resident #36 uses antidepressant medication r/t depression and insomnia. Resident #36 has potential to be physically/verbally aggressive is resistive to care at times r/t Dementia r/t bipolar disorder. Resident #36 is at risk for falls r/t unsteady gait. She uses mood stabilizer/anticonvulsants medications r/t bipolar. She uses antipsychotic medications r/t bipolar disorder. Record review of Resident #36's physician orders reflected the following: Zyprexa oral tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth two times a day related to bipolar disorder, current episode mixed, moderate dated 09/11/2025. Zyprexa oral tablet 2.5 MG (Olanzapine) Give 2 tablets by mouth at bedtime related to bipolar disorder, current episode mixed, moderate dated 09/11/2025. Record review of Resident 36's medication administration record scheduled for April 2026 reflected Zyprexa oral tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth two times a day related to bipolar disorder, current episode mixed, moderate. Start date- 09/11/2025. Hours: 07:00 a.m., 4:00 p.m. Record review of Resident 36's medication administration record scheduled for April 2026 reflected Zyprexa oral tablet 2.5 MG (Olanzapine) Give 2 tablet by mouth at bedtime related to bipolar disorder, current episode mixed, moderate. Start date-09/11/2025. Hours: 9:00 p.m.During an observation of administration of medication on 04/22/2026 at 08:34 a.m., revealed MA G administered Resident #36's scheduled medication Zyprexa oral tablet 5 MG instead of Zyprexa oral tablet 2.5 MG. During an observation of administration of medication on 04/22/2026 revealed MA G administered Resident #36's scheduled medication Zyprexa oral tablet 5 MG at 08:34 a.m. instead of at 07:00 a.m. During an interview on 04/23/2026 at 08:38 a.m. with MA G he stated he has been working in the facility as a CNA since 2018 and he was working as a MA for about 5-6 months. He stated this job is new to him. He had his medication administration training during onboarding to this job. He stated that medication administration training covered the most important thing is that medications must be given in the residents' rooms, to document if a resident refused medications and the reason for refusal. He stated that MAs must check the orders for medications and for the time medications to be given. He stated (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he has never given a wrong dose of medication because he checks that medication is right. He stated if he notes that a wrong dose of medication is given, he will notify his nurse. He stated he did not notice any changes in any residents yesterday. During an interview on 04/23/2026 at 09:53 a.m. with LVN B she stated she had been working here for 2.5 years. She stated she had medication administration in-service about a month ago. This training covered 8 medication administration rights such as right resident, right medication, right time, right dose, right strength, right route. She stated she has never given a wrong dose of medication to residents, but she had late administration of medications after calling the doctor and getting an order for it. She stated if the wrong dose of medication was administered, she would notify the doctor and get orders to monitor the resident. To avoid administering the wrong dose of a medication the nurse must check the order in the resident's chart and check the right medication to match it on the medication blister's pack. She stated that administering the wrong dose of medication can make residents sick, they can get adverse reaction , it is a medication error . During an interview on 04/23/2026 at 12:05 p.m. MA F he stated he has been working here for almost 2 years. He stated his last medication administration in-service was about 2 weeks ago. The training covered 6-7 rights of medication administration rights: right dose, route, strength, right time, right patient, right medication. There are a lot of things that can happen if a wrong dose of medication was given to a resident; it depends on the medication, but it would affect resident in a negative way. Any medication error must be reported to a charge nurse, and the charge nurse will take over. During an interview on 04/23/2026 at 3:59 p.m. with DON she stated she has been working here since August of 2025. She stated she recently had medication administration training but could not recall the exact date. She stated the training covered 6 medication administration rights: right patient, right medication, right dose, right time, right strength. She stated DON and ADON are responsible for providing training to the medication aids and nurses, responsible for checking med pass progress, calling in from pharmacy and hospice refills. She stated that if the wrong dose of medication was administered to a resident it can negatively affect the resident, depending on medication and if it was too much or too little of dose. The MAs were expected to notify nurses about any med errors and the residents affected and they will be closely monitored . During an interview on 04/23/2026 at 4:28 p.m. with ADM she stated she has been working in the facility since August of 2025. She stated she was not trained in administration of medications. ADM stated that administering a wrong dose of medication to a resident may cause side effects from the medication and negatively impact resident. The record review of the undated facility's Delivery, Receipt and Storage of Medication Policy reflected: 1. A triple check of these Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check#1: Select the Medication- label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged, indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away, and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions. 2. Medications are administered within 60 minutes before or after scheduled time, except for orders to administer with meals which must be administered based on mealtimes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (Resident #22) observed for infection prevention. 1. The facility failed to ensure CNA H was following the infection control procedures during peri-care when CNA H cleaned Resident #22's anal area first before cleaning his scrotum. 2. The facility failed to ensure CNA H and CNA I were following the infection control procedures when the same wipe was folded multiple times and used for multiple strokes while providing peri-care to Resident #22. 3. The facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and PPE was used when CNA H and CNA I provided care for Resident #22. Thes failures could place incontinent residents at risk for infection, hospitalization, and decreased quality of life. The findings included: Record review of Resident #22's face sheet, dated 04/22/26, reflected an [AGE] year-old male admitted to the facility 03/25/26. His diagnoses included chronic atrial fibrillation unspecified (persistent irregular heart rhythm), heart failure, unspecified (chronic, progressive condition where the heart cannot pump blood efficiently, causing fluid buildup in the lungs and body), and pulmonary fibrosis, unspecified (chronic, progressive scarring of lung tissue). Record review of Resident #22's comprehensive MDS assessment, dated 03/28/26, reflected a BIMS score of 12 which indicated moderately impaired cognition. The MDS reflected Resident #22 was dependent on helper for toileting hygiene. The MDS reflected he was always incontinent of both bladder and bowel. Record review of Resident #22's undated acute care plan reflected he had an ADL self-care performance deficit r/t weakness. Resident #22 has bowel and bladder incontinence r/t Activity Intolerance. Interventions - Clean peri-area with each incontinent episode. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Enhanced Barrier Precautions r/t Wounds. Goal- Enhanced barrier precautions will be maintained, and resident will not develop an opportunistic infection through the review date. Target Date: 07/02/2026. Interventions - Follow enhanced barrier precaution guidelines when providing close contact resident care. Post EBP signs on or beside the door to make precautions clear to those who are entering the room. Record review of Resident #22's order summary report reflected: Bilateral buttocks wound: cleanse with normal saline, pat dry, apply collagen to wound bed, then cover with dry dressing, change daily, one time a day for wound care, start date: 04/22/2026 Enhanced barrier precaution for wounds every shift, start date: 04/21/2026 Wound consult with skilled wound care surgical group until wounds resolved, ordered 04/21/2026 Micatin Cream 2 % (Miconazole Nitrate) Apply to groins topically one time a day for rash, start date: 04/22/2026 Santyl Ointment 250 UNIT/GM (Collagenase) Apply to left heel topically every day every shift for wound care, start date: 04/22/2026 Record review of Resident #22's completed orders reflected: Ceftriaxone sodium 1 GM solution reconstituted. Directions: Inject 1 GM intramuscularly one time only for dysuria and increased confusion for one day. Please give injection after labs have been collected. Completed on: 03/30/2026 Ceftriaxone sodium 1 GM solution reconstituted. Directions: Inject 1 GM intramuscularly one time a day for S/S of UTI for 3 days- Completed on: 04/03/2026 Ceftriaxone sodium 1 GM solution reconstituted. Directions: Inject 1 GM intramuscularly one time only for leukocytosis for 1 day- Completed on: 04/14/2026 During an observation of incontinent care on 04/22/2026 at 08:43 a.m., revealed CNA H and CNA I as they were preparing to perform incontinent care for Resident #22. They both put on Personal Protective Equipment before entering the high-risk Resident #22's room. Resident #22 was lying supine (on his back) in bed. CNA H explained his intention to perform incontinent care; resident verbalized a response. CNA H and CNA I went into the bathroom, washed their hands, then came out and put on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean gloves. CNA H performed incontinent care of Resident #22's genital area cleaning the resident's penis in circular motions first. CNA H used one cleaning wipe for one stroke, moving from clean area to dirty and from front to bottom. CNA H and CNA I assisted Resident #22 to turn to his left side, where the resident's buttocks were now exposed. CNA I was assisting Resident #22 to stay on his left side. CNA H removed his soiled gloves, performed hand hygiene, and put on clean gloves. Further observation at 08:51 a.m., revealed Resident #22 had a small bowel movement; CNA H cleaned Resident 22's anal area going from clean to dirty area and from front to back. CNA H removed his soiled gloves, performed hand hygiene, and put on clean gloves. CNA H started wiping Resident 22's scrotum which was covered with a white substance. CNA H used one wipe for two strokes on Resident #22's scrotum area. He then repeated the same steps with the second wipe before tossing wipe. Further observation revealed CNA I pulled out a new wipe and wiped the scrotum in a circular motion; she then folded the wipe and used it for one more swipe before tossing it. CNA I pulled out another fresh wipe, she made a swipe in a circular motion around the Resident #22's scrotum area, she then folded the wipe and made another two swipes folding the same wipe between swipes. CNA H and CNA I changed the gloves, performed hand hygiene, and applied a clean brief to Resident #22. CNA H and CNA I removed their gloves and gowns at Resident #22's bedside, performed hand hygiene, put on new gloves and assisted resident to reposition in bed by moving Resident #22 to the middle of his bed, fixing his pillow at the head and placing a pillow under his feet while both CNAs' scrubs were touching Resident 22's bedding. CNA H and CNA I gathered trash, removed gloves and washed hands in the resident's bathroom before leaving Resident #22's room. The CNAs changed gloves and cleansed their hands at appropriate intervals. The CNAs failed to wear gowns while providing high contact care to Resident #22 when the Signage noted outside of his door reflected that resident was on EBP. PPE was stored at Resident #22's door. During an interview on 04/23/2026 at 09:53 a.m. with LVN B she stated that she had infection control in-service training a couple of weeks ago. The training covered different isolation precautions and use of proper PPE. The training also covered hand hygiene topics. She stated she does not provide peri care to residents, but she knows the wipe needs to be disposed of after every stroke while providing peri care to residents. She stated that a charge nurse is looking over to provide proper peri care to residents. She stated that not following infection control procedure is an infection control issue, residents can get UTIs. During an interview on 04/23/2026 at 10:14 a.m. CNA H said he has been working here for about 19 years. He has been trained in infection control; his last infection control in-service training was 2 weeks ago. That training covered putting PPE on, washing hands, covering the linens when they are taken out of the residents' rooms that are on EBP, sanitizing hands every time you put gloves on, sanitizing hands before staff goes to residents' rooms and putting PPE on when providing care to residents on EBP.^He stated he had a check-off training on providing Peri care about 3 weeks ago. He stated that the check-off training covered the following steps: letting a resident know about the care to be provided, gathering all the supplies, providing privacy, washing hands, wiping resident's front private area first by using one wipe for one stroke and throwing the wipe away. CNA H stated after finishing providing peri care on resident's front area, turning resident on one side of the resident's body and continue providing peri care around resident's buttocks using one wipe for one stroke. CNA H stated using one wipe for multiple strokes is an infection control issue; residents can get UTIs due to cross contamination. He stated that Resident #22 had UTIs in the past. During an interview on 04/23/2026 at 11:34 a.m. with CNA I revealed she has been working in the facility for about 22 years. She stated she had an infection control in-service training a few weeks ago. The training covered the proper use of PPE and changing gloves. PPE must be used when providing care to the residents who have colostomy bags, wounds, foley bags, and to those residents that are in EBP rooms. When providing peri-care to residents the CNAs must make sure residents are not in pain and they are comfortable and explain to the residents the care will be provided. Start providing peri care on the resident's front genital area, going from clean to dirty area from top to bottom and after finishing with the front area (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675649	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident to be placed on his side. She stated when providing peri care to the resident's buttocks area by^wiping the area from dirty to clean; side to side first and then the buttocks' middle area, using a wipe with every stroke and throwing the wipe away. ^CNA I was able to recall that she was using the same wipe to clean the Resident # 22's scrotum area by folding a wipe after each stroke. She stated she thought it was okay to do so since she watched the Peri care training video where she saw the wipes were folded after each stroke. She stated that not following the infection control procedures while providing Peri care might cause residents to get sick. During an interview on 04/23/2026 at 3:59 p.m. with DON she stated that she recently had her annual infection control check offs and the ADON and she were providing the infection control check offs to the facility's staff annually where they are going step by step over the infection control policy and procedures and staff also demonstrates peri care skills. She stated that she does not remember providing peri care in-service training to the staff. ^^She stated that staff were expected to use one wipe for one stroke while providing peri care to residents; not following this is an infection control concern; the residents can get UTIs. During an interview on 04/23/2026 at 4:28 p.m. with ADM she stated she has been trained in infection control. She stated she recently took infection prevention control course required by the CDC and the HHS infection control^modules required by State. She stated that she is familiar with providing peri care to residents in general. It is recommended to start providing peri care from resident's front and then proceed to back, doing strokes from front to back, and it must be done from the clean area of the body to dirty using clean supplies. During an interview on 04/23/2026 at 4:43 p.m. with ADON she stated that she is trained in providing peri care to residents; she had training early this year. She stated it is expected that during providing peri care to residents staff must go from clean to dirty areas using a single wipe for each stroke. Not following this expectation is an infection control issue and potentially may cause UTIs. She stated that any staff that is providing direct care to the residents in EBP rooms must put the PPE on at the entrance to the room and the PPE must be removed at the door before exiting the room. The facility's infection control policy was requested on 04/21/2026. The policy was not provided during the survey.