

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Park Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 2122 Park Bend Dr Austin, TX 78758	
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that each resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 (Resident #1) of 29 residents on 300 Hall reviewed for Privacy and Confidentiality. The facility failed to ensure Resident #1's personal health information was protected from being viewed by unauthorized person when the RN left Resident #1's personal information displayed on the computer screen located at the charting station on 300 Hall while unattended. This failure could place residents' personal information at risk of being exposed to unauthorized individuals. The findings included: Observation on 2/27/2026 at 10:12 a.m., revealed the computer screen on the RN's charting station on 300 Hall was open and unlocked, with Resident #1's personal clinical information displayed and visible to unauthorized individuals, including visitors or other residents. Other nursing staff members were observed walking on the 300 Hall near the charting station at the same time. Nobody was observed looking at the screen at that time, but other residents, unauthorized staff or visitors could be potentially walking by the charting station. The RN came to her charting computer at 10:15 a.m. from residents' room on 300 Hall. During an interview on 2/27/2026 at 10:14 a.m., RN stated that she was in-service on HIPAA five months ago. She stated the HIPAA in-service included instructions on not sharing residents' private clinical information with unauthorized individuals and to lock the computer screen when stepping away from the charting computer. She stated everybody who worked with charting computers were responsible for closing and locking the computer when not in attendance. She stated leaving the screen unlocked with Resident #1's clinical information displayed could be harmful for the residents because anybody could see it. She stated she was at fault for not locking the computer before going to answer the call light. During an interview on 2/27/2026 at 3:05 p.m., the ADM stated he received HIPAA training upon hire and a few months ago which covered the importance of maintaining the residents' private information. He stated whoever used the computer was responsible for shutting it down to ensure the residents' information was not visible. He stated the potential risk for not shutting down charting computers could be a breach of residents' privacy. He stated all staff completed HIPAA in-service upon hire and annually. He stated the last staff HIPAA in-service was conducted in September 2025 and on 02/27/2026, after the incident. During an interview on 2/27/2026 at 3:21 p.m., the DON stated the facility's HIPAA policy was to minimize the charting computers' screens when stepping away. He stated if the computer screens were not minimized, someone could have unauthorized access to private clinical information displayed on the screen. He stated HIPAA in-services were included employees at hire and annually through computer modules which included instructions on locking the computer screens. He stated the person who works with residents' private clinical information should lock the screen before walking away. He stated the potential negative effect was unauthorized disclosure of residents' private information and could affect residents' dignity. Record review revealed HIPAA in-services, dated 09/17/2026, indicated the RN completed and signed the in-service. Record review of facility's</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675862
		If continuation sheet Page 1 of 2

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Privacy Notice policy, revised on 03/2014, revealed h. (1) the facility is required by law to maintain the privacy of patient health information. Record review of facility's Resident Rights policy, revised on 01/2021, revealed 3. Unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws, governing privacy of information issues.		