

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  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Park Bend Health Center		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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide accurate PASRR screenings for individuals with a mental disorder for 1 (Resident #72) of 6 residents reviewed for PASRR.</p> <p>The facility failed to complete an accurate PASRR level one screening after Resident #72 was admitted with a negative PASRR Level 1 screening but had a mental illness.</p> <p>This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require.</p> <p>Findings included:</p> <p>Record review of Resident #72's quarterly MDS assessment, dated May 9, 2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of Paroxysmal Atrial Fibrillation (irregular heart rhythm episodes are intermittent and short-lived), Atherosclerotic Heart Disease (buildup of fats, cholesterol and other substances in and on the artery walls), Sick Sinus Syndrome (heart rhythm problems caused by a malfunctioning sinus node) and Major Depressive Disorder. Her BIMS score was a 09 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #72's care plan dated last revised 08/13/2024 reflected resident was on an antidepressant medication due to depression.</p> <p>Record review of Resident #72's PASRR Level 1 screening, dated 05/20/2023 conducted by an acute care hospital, reflected Resident #72 was negative for mental illness, intellectual disability, and developmental disability.</p> <p>Interview on 06/12/25 at 11:15AM, with MDS Coordinator J revealed she had been the MDS coordinator for the facility for 1 year. MDSC J stated that a mental illness would result in a positive Level 1 PASRR screening. If a resident had a positive Level 1 PASRR screening, it would lead to a Level 2 PASRR screening. MDSC J stated that Resident #72's diagnosis of Major Depressive Disorder, should have resulted in a positive Level 1 PASRR. MDSC J stated this could negatively impact a resident by not being provided services that they qualify for.</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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/12/25 at 11:33 AM, with MDS Coordinator K revealed she had been the MDS coordinator for the facility for 23 years. MDSC K stated that a mental illness, intellectual disability and developmental disability would result in a positive Level 1 PASRR screening. MDSC K stated a resident that had a positive Level 1 PASRR screening, would qualify for a Level 2 PASRR screening. MDSC K stated that Resident #72's diagnosis of Major Depressive Disorder should have resulted in a positive Level 1 PASRR screening. MDSC K stated this could negatively impact a resident by not being provided the services that were needed.</p> <p>Interview on 06/12/2025 at 12:00PM with the DON revealed that she had been the DON for the facility for 2 weeks. The DON stated that Resident #72 had a diagnosis of Major Depressive Disorder, which should indicate a Positive Level 1 PASRR screening. The DON stated Resident #72 did have a diagnosis of Dementia but it was not her primary diagnosis. The DON stated not having proper PASRR services could negatively impact residents by being at risk of rapid decline and not getting the services necessary for her diagnosis.</p> <p>Interview on 06/12/2025 at 1:00PM with the ADM revealed that he had been the ADM for the facility for 3 years. The ADM stated that a positive Level 1 PASRR could be from mental health issues and intellectual disabilities. The ADM stated if the Level 1 PASRR was positive, residents were to be screened for Level 2 PASRR. The ADM stated Resident #72 had a diagnosis of Major Depressive Disorder. The ADM stated this should have resulted in a positive Level 1 PASRR. The ADM stated this could negatively impact residents by missing out on the beneficial services that were available.</p> <p>Review of the facility's PASRR policy dated last revised 05/10/2021 revealed The intent of this guideline is to identify residents with Mental Illness, Intellectual Disability or Developmental Disability/Related Conditions and to ensure they are properly placed, whether in community or in a Nursing Facility and to ensure they receive the services they require for their MI, ID or DD. This document revealed the following:</p> <ol style="list-style-type: none"> <li>1. <ul style="list-style-type: none"> <li>In the event of a positive PL1 that indicate the individual may have ID/DD or MI.</li> <li>a. <ul style="list-style-type: none"> <li>The MDS coordinator will review the PE , print the form and place in the medical record.</li> </ul> </li> </ul> </li> <li>2. <ul style="list-style-type: none"> <li>When it is determined that PL1 was filled out incorrectly, the MDS coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form.</li> <li>a. <ul style="list-style-type: none"> <li>If the case worker is unwilling/unable to correct the PL1 that contains a potential error, they will complete and submit a form 1012 (MI) or new PL1 (ID/DD).</li> </ul> </li> </ul> </li> </ol>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 10 (Resident #44) residents reviewed for care plans.</p> <p>The facility failed to update the care plan for Resident #44 to reflect how to meet the needs of the resident when a gastrointestinal tube becomes dislodged.</p> <p>This failure placed the resident at risk of complications with indwelling devices.</p> <p>Findings include:</p> <p>Record review of Resident #44's face sheet dated 06/12/2025 reflected Resident #44 was a [AGE] year-old female admitted to the facility on [DATE] with pertinent diagnoses of intractable epilepsy (uncontrollable seizures) , mild protein calorie malnutrition (a mild nutrient deficiency), aphasia (inability to speak), dysphasia (inability to swallow), gastronomy status (feeding via tube in the stomach), intellectual disability, anoxic brain damage (brain damage due to lack of oxygen).</p> <p>Record review of Resident #44's MDS dated [DATE] indicated Resident #44 had no BIMS score which indicates the BIMS was not attempted. Resident #44 is coded as a complete dependence on caregiver for all efforts related to bathing.</p> <p>Record review of Resident #44's care plan updated on 03/20/2025 reflected, Check for tube placement and gastric contents/residual volume. No information was included on care planning for tube removal or replacement if necessary.</p> <p>Record review of Resident #44's progress notes dated 03/27/2023 revealed a physician visit due to PEG tube infection after PEG tube had become dislodged a week prior.</p> <p>Record Review of Resident #44's progress notes dated 03/20/2024 revealed a physician visit due to PEG tube replacement due to it becoming dislodged.</p> <p>Record review of Resident #44's progress notes dated 12/18/2024 revealed resident was transferred to the hospital to replace PEG tube after CNA had accidentally removed PEG tube while changing resident.</p> <p>Observation of Resident #44 on 06/10/2025 at 1:30 pm revealed resident lying in bed. Resident #44 was able to make eye contact but was unable to answer any questions or communicate.</p> <p>In an interview with the RDN on 06/11/2025 at 1:31 pm, he stated he had no concerns for Resident #44. He stated her weight was stable, she had tolerated her feeds well and was healthy. He stated he had no opinion about her tube becoming dislodged because that was outside of his area of expertise. He was unaware about care plans and refused to comment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #44's RP on 06/11/25 at 01:57 PM, she stated she had no issues or concerns for her care. They communicated well and always notified her if Resident #44 had to go to the hospital. She stated she knew there were issues, but no complications this year as far as she knew. She stated she felt like Resident #44 was well taken care of.</p> <p>In an interview with CNA C on 06/11/2025 at 2:30 pm she stated that on 12/18/2024 she was giving the resident a bed bath when the PEG tube had become dislodged. Specifically, it was while she was putting Resident #44's shirt back on. She stated that when it happened, she ran to grab LVN A. LVN A tried to replace it, but they were instructed to send her out to the hospital. She stated that she had training on a bed bath at CNA school. She had not had any training on handling PEG tubes while working at the facility. She stated they did not provide any further education after the incident. She believed the resident was unharmed because the resident was smiling and made no noises or facial grimacing that could have been considered a painful response. She stated she thought it was important to have training and action plans for bed baths on her care plan.</p> <p>Interview with LVN A on 06/11/2025 at 2:45 pm revealed that she was the nurse on the hall when Resident #44's PEG tube became dislodged. She stated CNA C had immediately notified her when the tube became dislodged. The CNA reported that while pulling Resident #44's top down after a bed bath the PEG tube became dislodged. She stated the tube had come out twice before. She stated during the incident there was no bleeding, no obvious signs of pain. She cleaned the area, covered it, and prepared Resident #44 to be transferred to the hospital. She stated it would be important to have the steps to take when a tube is dislodged on the care plan because it would help guide another nurse who was unfamiliar with Resident #44. She stated the only training CNAs got was communication between the LVN and CNAs to be careful around the tube. She stated she was responsible for ensuring that the CNAs were handling the tube correctly while giving a bed bath.</p> <p>In an interview with the MD on 06/12/25 at 09:40 AM she stated that she had no concerns for Resident #44's care at the facility. She stated that Resident #44's feeding tube can come out and that the stoma opening had significant scar tissue around the stoma. She said the risk of infection was very low especially if staff had put in a catheter to protect the opening and cover it. She stated it was acceptable to send the resident out to the hospital to replace the PEG tube. She stated that all things related to PEG tubes should have been care planned.</p> <p>In an interview with the DON on 06/12/2025 at 10:26 am she stated that she had been at the facility for two weeks and was not aware of the incident with Resident #44's PEG tube being dislodged during care. She stated that the CNAs should be aware of who had indwelling devices. She stated that any sort of change of condition that required hospitalization should be on the care plan. She stated that it would have helped nurses know what to do when that did happen. This would have ensured timely care without confusion.</p> <p>In an interview with the ADM on 06/12/2025 at 1:45 pm, she stated that care plans were individualized. She stated that anything they needed to provide excellent care should be on the care plan. She stated the care plans should have been updated after the morning meeting. The DON or MDS nurse was responsible for updating care plans. She stated there was very little risk to the resident because the nurse acted quickly without having to look at the care plan.</p> <p>Care plan policy was requested on 06/12/2025 from Adm but not provided before exit.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure that nurse aides were able to demonstrate competency in skill and techniques necessary to care for 1 of 10 resident's needs (Resident #44) related to PEG Tubes.</p> <p>The facility failed to ensure CNA C was appropriately trained on providing bed baths for residents with PEG tubes for Resident #44.</p> <p>This could lead to a risk of infection and medical complication, and a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of face sheet dated 06/12/2025 reflected Resident #44 was a [AGE] year-old female admitted to the facility on [DATE] with pertinent diagnoses of intractable epilepsy (uncontrollable seizures) , mild protein calorie malnutrition (a mild nutrient deficiency), aphasia (inability to speak), dysphasia (inability to swallow), gastronomy status (feeding via tube in the stomach), intellectual disability, anoxic brain damage (brain damage due to lack of oxygen).</p> <p>Record review of Resident #44's MDS dated [DATE] indicated Resident #44 had no BIMS score which indicated the BIMS was not attempted. Resident #44 is coded as a complete dependence on caregiver for all efforts related to bathing.</p> <p>Record review of Resident #44's care plan updated on 03/20/2025 reflected, Check for tube placement and gastric contents/residual volume. Nothing in the care plan related to providing bed baths.</p> <p>Record review of Resident #44's progress notes dated 12/18/2024 revealed resident was transferred to the hospital to replace PEG tube after CNA had accidentally removed PEG tube while changing resident.</p> <p>Observation of Resident #44 on 06/10/2025 at 1:30 pm revealed resident lying in bed. Resident #44 was able to make eye contact but was unable to answer any questions or communicate.</p> <p>In an interview with Resident #44's RP on 06/11/25 at 01:57 PM, she stated she had no issues or concerns for her care. They communicated well and always notified her if Resident #44 had to go to the hospital. She stated she knew there had been issues, but no complications had occurred this year. She stated she felt like Resident #44 was well taken care of.</p> <p>In an interview with CNA C on 06/11/2025 at 2:30 pm she stated that on 12/18/2024 she was giving the resident a bed bath when the PEG tube had become dislodged. Specifically, it was while she was putting Resident #44's shirt back on. She stated that when it happened, she ran to grab LVN A. LVN A tried to replace it, but they were instructed to send her out to the hospital. She stated that she had training on a bed bath at CNA school. She had not had any training on handling PEG tubes while working at the facility. She stated they did not provide any further education after the incident. She believed the resident was unharmed because the resident was smiling and made no noises or facial grimacing that could have been considered a painful response.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA B on 06/11/2025 at 1:45 pm she stated that she had been working there 3 years. She stated that she was not checked off on providing bed baths. She stated it was common sense just to be careful around providing care to a resident with a PEG tube. She stated if she ever had questions she would ask the nurse. She stated that they had in-services on tube feedings, but could not remember when they had occurred.</p> <p>Interview with LVN A on 06/11/2025 at 2:45 pm revealed that she was the nurse on the hall when Resident #44's PEG tube became dislodged. She stated CNA C had immediately notified her when the tube became dislodged. The CNA reported that while pulling Resident #44's top down after a bed bath the PEG tube became dislodged. She stated the tube had come out twice before. She stated during the incident there was no bleeding, no obvious signs of pain. She cleaned the area, covered it, and prepared Resident #44 to be transferred to the hospital She stated the only training CNAs got was communication between the LVN and CNAs to be careful around the tube. She stated she was responsible for ensuring that the CNAs were handling the tube correctly while giving a bed bath.</p> <p>In an interview with the MD on 06/12/25 at 09:40 AM she stated that she had no concerns for Resident #44's care at the facility. She stated that Resident #44's feeding tube can come out and that the stoma opening had significant scar tissue around the stoma. She said the risk of infection was very low especially if staff had put in a catheter to protect the opening and cover it. She stated it was acceptable to send the resident out to the hospital to replace the PEG tube. She expected the staff to be careful around the PEG tubes and know how to provide a bed bath around the PEG tube.</p> <p>In an interview with the DON on 06/12/2025 at 10:26 am she stated that she had been at the facility for two weeks and was not aware of the incident with Resident #44's PEG tube being dislodged during care. She stated that the CNAs should be aware of who had indwelling devices. She stated that any sort of change of condition that required hospitalization should have required a reeducation or a 1-1 education session. She stated that education was important, but the CNA should have asked for help if bathing became too difficult. She stated that she believed the risk to the resident was low because they had done the right thing.</p> <p>In an interview with the ADM on 06/12/2025 at 1:45 pm, she stated that the CNAs had reeducation on bed baths after that event, but CNAs were not assessed on providing bed baths for residents with PEG tubes. She stated that education was important. She stated that it was important to get education on specific topics for specific residents. She stated the previous DON did the initial check offs, but they could not find the initial check off for CNA C. She stated that residents needed trained caregivers for their specific medical conditions to improve their quality of life.</p> <p>Record review of CNA C's staff file on 06/12/2025 revealed there was no assessment of bed baths or PEG tubes.</p> <p>Record review of in-services on 06/12/2025 revealed no in-services related to bed baths or PEG tubes.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (Resident #19) of 5 residents and 3 (100 Hall MC 200 Hall MC and 300 Hall MC) of 8 medication carts reviewed for pharmaceutical services.</p> <p>A total of 29 loose pills were observed in 100 Hall MC 200 Hall MC and 300 Hall MC</p> <p>A total of 3 medications were observed as expired in 100 Hall MC 200 Hall MC and 300 Hall MC</p> <p>These failures could place residents at risk of not receiving all their prescribed medications, which could exacerbate their illness, and expired medications could have a decrease in effectiveness or make the resident sick.</p> <p>Findings included:</p> <p>Observation on 06/12/2025 at 10:03 am revealed 6 loose pills in the drawers of the 100 hall MC .</p> <p>Observation on 06/12/2025 at 10:17 am revealed 21 loose pills in the drawers of the 200 hall MC .</p> <p>Observation on 06/12/2025 at 11:25 am revealed 2 loose pills found in the drawers of the 300 hall MC .</p> <p>Observation on 06/12/2025 at 11:18 am revealed 2 bottles of nystatin powder in the drawers of 100 Hall MC for Resident #19 with expiration dates of 03/24/2025 and 06/03/2025 prescribed for fungal infection on the skin.</p> <p>Observation on 06/12/2025 at 11:18 am revealed a foil packet patch labeled Asper creme without a resident name with an expiration date of December 2024.</p> <p>Record review of Resident #19's face sheet dated 06/12/25 reflected she was admitted to the facility on [DATE]. Her diagnoses included dementia, iron deficiency anemia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, cerebral infarction with right sided weakness, and a history of falling.</p> <p>Record review of Resident #19's Quarterly MDS dated [DATE] reflected a BIMS Score of 13, which indicated no cognitive impairment. Section GG functional abilities reflected Resident #19 required substantial/maximal assistance for chair/bed to chair transfer, bed mobility, sit to lying, lying to sitting on the bed, sit to stand, and shower, and she used a wheelchair for mobility.</p> <p>Record review of Resident #19's Care Plan, last revised on 03/26/25, reflected she had diabetes mellitus. The goal reflected Resident #19 would have no complications related to diabetes mellitus through the review date. Relevant interventions included check all of body for breaks in skin and treat promptly as ordered by doctor, and to monitor/document/report PRN any signs and symptoms of infection to any open areas: Redness, Pain, Heat, Swelling, or Pus formation.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with MA F on 06/12/2025 at 10:30 am revealed that she was unaware there were loose pills in the cart. She was unable to identify the pills or what resident they came from. She was supposed to be checking daily or weekly for loose pills and expired medication. She stated she was trained on medication administration when she started at the facility. They were required to do a skills check-off sheet that demonstrated they could accurately administer medications. She stated that if she found a loose pill she was to get another staff member, crush it, and place it in the sharp's container. She stated that sometimes the medications came accidentally get popped out because the drawer was very full. She was unable to say if any risks were present for the residents because they always had extra in the medication storage room.</p> <p>Interview with MA G on 06/12/2025 at 11:29 am revealed that he did not know there were loose pills in his cart. He had checked his cart within the last week for expired medications and loose pills. He was trained on medication administration and was required to demonstrate the administration while someone was watching. He stated that if a loose pill was found he was supposed to crush it and place it in the sharps container. He stated the residents had not run out of medication and that there were always extra medications in the storage room.</p> <p>In an interview with the ADON on 06/12/2025 at 11:52 am she stated that she had been working at the facility for 24 years. She revealed the LVNs and MAs were supposed to be checking for loose and expired medications at least daily and at every shift. It was unacceptable that there were loose pills in the cart. She stated that there were very few risks to the resident because they ordered the medication refills about a week ahead of time. She stated that she was not concerned for residents accidentally ingesting the medications because they were locked up. She revealed that keeping the carts clean and free from expired medications was a part of their job duties. She stated anyone who administered medication completed a medication check off sheet that was evaluated by another nurse or herself. She stated they have done in-services recently to reeducate the medication aides on how to keep carts clean.</p> <p>In an interview with the DON on 06/12/25 at 10:26 AM she revealed that the medication cart should have been clean and free from any loose pills. The MAs should have been completing a full cart audit weekly to ensure that everything was clean and organized. She stated that it was her and the ADON's responsibility to ensure the MAs had completed their job correctly. The pharmacist had come to the facility and completed a few cart audits as well. She stated that to her knowledge no loose pills had been given to residents, so there was no risk to residents. She stated that the facility kept backups of all medication in the medication bank in the medication storage room. According to her, there was no risk of residents running out of medication.</p> <p>Interview with the ADM on 06/12/2025 at 1:46 pm, revealed that it was unacceptable to have loose pills. She stated the DON and ADON audited the MCs 1 time per month. She stated they completed an in-service in the last 6 months for medication administration. She stated that anyone who passed medication was responsible to ensure that the cart was clean, free from loose pills, and expired medication. She stated that there was no risk to residents because they had intentionally kept back up medication in the storage tower in the medication storage room for that reason.</p> <p>Record review of medication storage policy, undated, titled Delivery, Receipt and Storage of Medication reflected it did not contain any language related to policies about storing non-refrigerated medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Requested cart audit records from DON on 06/12/2025, but none were provided before exit.</p> <p>Record review of in-services on 06/12/2025 revealed no in-services were available on medication administration in the last 6 months</p>		