STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 12021 Metric Blvd 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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 16 (Resident #1, and Resident #2) residents in 1 of 1 dining room. The facility failed to promote Resident #1 and 2's dignity while dining when staff did not serve the residents their lunch tray at the same time as other residents at the same table. This failure could affect all residents who were eat in the dining room, by contributing to poor self-esteem, and unmet needs. Findings included: Review of Resident #1's Face Sheet dated 004/01/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, type 2 diabetes, high blood pressure, insomnia, heart failure, respiratory disease, depression, protein-calorie malnutrition, high levels of fat particles in the blood, psychoactive substance use, psychoactive substance induced mood disorder, constipation, nausea and vomiting, age related disability, pain, long tern use of anticoagulants, and long-term use of aspirin . Record Review of Resident #1's MDS stated his BIMS 03 severely impaired. Review of Resident #2's Face Sheet dated 03/01/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's diagnoses included dementia, psychotic disturbances, mood disturbance, anxiety, constipation, disturbance of salivary secretion, cough, nasal congestion, bacterial infection, heart disease, shortness of breath, pancreatitis, paralysis on left side, depressive disorder, vitamin deficiency, high blood pressure, seizures, kidney disease, prostatic cancer, convulsions, altered mental state, nervous system disorder, and slow heartbeat . Record review of Resident #2's MDS stated his BIMS was 06 severe impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the dining services on 04/01/2024 at 12:00PM revealed that Resident #1 and Resident #2 were sitting at the same table with one other resident. Resident #1 did not receive his meal tray until 10 minutes after his table mate received her tray. Resident #2 did not receive his meal tray until 17 minutes after his table mate received his tray . An interview with Resident #1 on 04/01/2024 at 12:11 pm was unsuccessful. Resident #1 did not respond to any questions. An interview with Resident # 2 on 04/01/2024 at 12:17 pm was unsuccessful. Resident just sighed when asked questions. An interview with CNA D on 04/01/2024 at 12:19 pm revealed the policy for dining tray pass was that all residents at the same table were to receive their meal tray before staff moved on to the next table. He stated the nurses were responsible for ensuring all residents were served at the same table. CNA D stated that by not feeding the residents at the same table at the same time could make the resident feel like he or she were forgotten and get upset. He stated that he was not sure why Resident #1 and Resident # 2 did not get their meal trays, that the kitchen had not sent the residents trays out at the same time. An interview with KS E on 04/01/2024 at 04:21 pm revealed the policy for tray pass in the dining room was they started with one table ensure all residents had their food before moving to the next table. He stated that by not giving a resident his/her tray at the same time as others at the table could result in the resident getting upset, taking food from other residents and cause a fight. KS E stated he was not sure what happened he stated the nursing staff should have told the kitchen the residents needed their trays, that was why the nursing staff was at the window. An interview with CK F on 04/01/2024 at 4:33PM revealed that he normally made sure that all residents at the same table had their food before moving to the next table. He stated he checked the tray and then the nurse and CNA was supposed to check the tray and let the cook know if a resident was missed. CK E stated a resident may feel left out or like he or she is being punished by staff or the staff do not like them because they did not get their meal tray. An interview with the DON on 04/01/2024 at 4:59 pm revealed that she did not know if there was a policy on passing trays to residents at the same table. She stated they helped residents that needed assistance. She stated that staff were to give the trays to everyone at the same table and then move to the next table. The DON stated that the nurses and CNAs were responsible for checking to ensure each resident at the table have their meal tray. She stated residents who did not get their trays at the same time as their table mate could cause the resident to be sad and may not be able to express themselves. She stated that she did not know why the residents did not get their trays at the same time as their table mate. An interview with the Nurse A on 04/01/2024 at 5:17 pm revealed the policy was staff fed all the residents at the same table before moving on to the next table. She stated the nurses were responsible for ensuring that all residents at the same table have their trays before moving on to the next table. She stated if residents did not get their food at the same time residents may take other residents' food. Nurse A stated the resident may feel ignored if they did not get their food at the same time as their table mates. She stated she was not sure why the residents had to wait for their food. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 04/01/2024 at 5:44 pm revealed that the policy was to ensure residents were being served close to the same time. All residents at one table should be served before moving on to the next table. He stated it was a collaborated effort between dining and dietary to make sure that all residents at the same table had their meal tray before moving on to the next room. He stated that when a resident did not get their tray at the same time it could cause the resident to get frustrated and have a dignity issue. The Administrator stated that the residents did not get their trays due to poor communication between the departments. Record Review of the Dining Experience Staff Responsibility Policy dated 2013 revealed individuals at the same table would be served and assisted at the same time.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview, and record review the facility failed to ensure resident rights for personal privacy for two of seven (Resident # 3, and Resident # 4) residents observed for resident rights. CNA B and CNA C did not provide privacy to Resident #4 when providing care. The facility failed to provide privacy to Resident #3 while she was lying in bed with no clothing on from the waist down. The deficient practice could affect all residents in the facility by placing them at risk for loss of dignity and privacy. Findings included: Review of Resident #3's Face Sheet dated 04/01/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included dementia, obesity, insomnia, anxiety disorder, high blood pressure, long term use of aspirin, reflux disease, constipation, muscle spasm, chest pain, pain, convulsions, and protein-calorie malnutrition . Record Review of Resident #3's MDS revealed her BIMS was a 13 cognitively intact. Resident #3 is a maximum assist with activities of daily living. Review of Resident #4's Face Sheet dated 04/01/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4's s diagnoses included epilepsy, other symptoms and signs involving the musculoskeletal system, rash and other nonspecific skin eruption, dry skin, cough, artery disease, reflux disease, constipation, patient noncompliance with medication regimen, patient noncompliance with other medical treatment and regimen, hardening of muscle right upper arm, contractor of muscle left lower leg, paralysis on right dominate side, nausea, difficulty swallowing, an opening in the abdomen for the colon, urinary incontinence, chronic pain, stroke, hyperthyroidism, vitamin deficiency, schizoaffective disorder, and anxiety disorder . Record review of Resident #4's MDS revealed his BIMS was a 08 moderately impaired. Resident #4 was a maximum assist with activities of daily living. Observation of residents on 04/01/2024 at 12:07 pm revealed CNA B and CNA C were in Resident #4's room. CNA C was fastening the right side of the resident's brief. CNA B was standing at the foot of the bed with the door open and the privacy curtain not pulled closed. There was a shower bed in the resident's room. CNA B proceeded to come out the room after approx. two minutes leaving the resident's door open. CNA C came over to the door and closed it after CNA B walked away. Observation of residents on 04/01/2024 at 2:11 pm revealed Resident #3 was exposed from the waist down with just her brief on. Resident #3's door was open, and the privacy curtain not pulled closed. She did not have any covers, sheets or pants covering her brief. There were no staff on the hall at the time. Resident #3 was seen from the hall laying on her bed. (continued on next page)

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Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/01/2024 at 2:11 pm with Resident #3 was unsuccessful. Resident #3 was asleep and did not wake up when Surveyor knocked on her door. An interview with CNA B on 04/01/2024 at 1:39 pm revealed that she had been trained on resident rights. She stated she did not communicate with CNA C and let her know that she was going to open the door. She stated she should have told CNA C so that she could pull the privacy curtain closed or cover the resident before she opened the door, that way the resident would not be exposed. She stated by not closing the door or privacy curtain when providing care, it was an invasion of the resident's privacy. An interview with CNA C on 04/01/2024 at 2:00pm revealed she has been trained on resident rights. She stated that CNA B opened the door while she was fastening the brief on the resident. She stated she did not tell her she was going to open the door so that she could cover the resident or pull the privacy curtain. She stated by not giving the resident privacy during care that could cause the resident to become insecure. An attempted interview with Resident #3 on 04/01/2024 at 2:16pm revealed the resident was asleep and did not respond to surveyor knocking on the door. An Interview with Resident #4 on 04/01/2024 at 2:18pm revealed he did not want to talk to surveyor. He stated it was none of the surveyor's business. An interview with the DON on 04/01/2024 at 4:47pm revealed that regardless of the resident's mental state staff were to provide privacy to the resident when providing care. She stated the door was to be closed and the privacy curtain should be pulled closed. She stated that it may not have affected the resident physically, but it might affect the resident's emotional state. She stated that no one wanted to be exposed. She stated that she thought that the residents were left exposed subconsciously. She stated she drilled in the staffs' head that when providing care, they needed to ensure the resident is receiving privacy by closing the door and pulling the privacy curtain. An interview with Nurse A on 04/01/2024 at 5:22pm revealed staff were to close the door or pull the privacy curtain to where the resident is not seen when providing care. She stated at no time was the door or curtain supposed to be open when providing care to a resident. She stated that by not respecting the residents right to privacy could make the resident feel like their rights are being violated. An interview with the Administrator on 04/01/2024 at 5:34pm revealed staff had been trained on resident rights. He stated staff were to ensure residents had privacy and dignity when giving care. The Administrator stated that staff were never to leave the door open when providing care to a resident. He stated that the aide failed to communicate with her colleague that she was going to open the door so that the other aid could cover the resident. Record Review of Resident Rights Guidelines for All Nursing Procedures dated October 2010 revealed staff were to close the room entrance door and provide for the resident's privacy.

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	675918	A. Building B. Wing	04/01/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49097 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the refrigerator were dated, labeled, and sealed appropriately. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observations of the facility's kitchen refrigerator on 04/01/2024 at 9:22am revealed the following items were not sealed and exposed to air, labeled, or dated: Two plastic bags of cheese not dated, labeled, and sealed. One plastic bag of ham deli meat not dated, labeled, and sealed. 4 Prepped cups of orange juice not dated, labeled. Milk in a pitcher not dated and labeled. 8 Prepped cups of ketchup, ranch and thousand island dressing not dated and labeled. A container of strawberries not labeled and dated. One plastic bag of lettuce not labeled and dated. Observations of the facility's kitchen freezer on 04/01/2024 at 9:24am revealed the following items were not sealed and exposed to air, labeled, or dated: One plastic bag with mini pizza's was not labeled, dated, and sealed. One plastic bag of chicken was not label, dated, and sealed. One plastic bag of waffles was not label and dated. One box of hamburger meat was not label, dated, and sealed. One box of what appeared to be dough squares was not label, dated, and sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the facility's kitchen dry food storage on 04/01/2024 at 9:25am revealed the following items were not sealed and exposed to air, labeled, or dated: One container of Cheerios cereal was not label and dated. One container of Corn Flakes cereal was not label and dated. One container of Fruit Loops cereal was not label and dated. One container of what appeared to be white four was not label, dated and sealed. One container of sugar was not label, dated, and sealed. One container of rice was not label, dated, and sealed. An interview with KS E on 04/01/2024 at 4:16pm revealed all food in the refrigerator, freezer and dry storage area were to be labeled, dated, and sealed once opened. He stated everyone in the kitchen was responsible for labeling, dating, and sealing food when they put it up or open the food. He stated he did not know why the items were not labeled, dated, and sealed in the refrigerator. He said he thinks it was because the facility had been short staff in the kitchen and the staff were rushing to get everything done. KS E stated that by not label, dating and sealing items it falls under infection control and could cause residents to get sick. An interview with CK F on 04/01/2024 at 4:29pm revealed that as soon as a staff member was ready to put food that had been opened or prepped up it was to be labeled, dated, and sealed. He stated everyone in the kitchen who prep or cook food is responsible for label, dating and sealing food. He stated by not label, dating and sealing food could result in someone getting sick or serving food that has spoiled. He stated he did not know why the food was not label, dated, and sealed. An interview with the Administrator on 04/01/2024 at 5:44pm revealed stated staff are trained in the kitchen on label, dating and sealing food. He stated staff are expected to follow the policy of label and dating to ensure that the food is fresh. He stated staff are supposed to label, and date items when they are first opened, and the KS is supposed to ensure everything opened was labeled and dated. The Administrator stated that if staff do not label and date food items it could end up spoiled and cause the resident an adverse reaction. He stated that staff just failed to ensure everything was labeled and dated before putting up. Record Review of Food Storage Policy dated 2013 revealed dry storage food should be dated as it is placed on the shelves. Date marking to indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold, or discarded will be visible on high-risk food. Record Review of Food Storage Policy dated 2013 revealed refrigerated and frozen foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by date or frozen or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of 2022 Food Code U.S. Food and Drug Administration revealed, Section 3-501.17 specifies ready-to-eat, time/temperature control for safety (TCS) food prepared in a food establishment and held longer than a 24-hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises.