

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 05/20/2024
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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart and ensure infection control measures during implementation of care, handling, cleaning, storage and disposal of equipment, supplies, biohazardous waste and including infection control practices for mechanical ventilation/tracheostomy care including the use of humidifiers were followed by staff for 1 (Residents #1) of 5 residents reviewed for respiratory care,</p> <p>The facility failed to ensure Resident #1's nasal cannulas and tubing were properly stored when not in use.</p> <p>This deficient practice could place residents at risk of cross-contamination and illness.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet, dated 05/20/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and diagnoses including: hypertension (A condition in which the force of the blood against the artery walls is too high) and history of shortness of breath.</p> <p>Record review of Resident #1's Baseline Care Plan, undated, revealed nothing related to respiratory therapy and to see MAR for current medications.</p> <p>Record review of Resident #1's Active Orders, dated 05/20/24, revealed she had an order started on 05/17/24 for O2 at 2 liters by nasal cannula continuously and O2 saturation was to be checked every shift. Resident #1 also had an order started on 05/15/24 to change O2 tubing every Sunday night shift, clean filter, wipe machine with sanitized wipes, and check for O2 magnet outside door. Resident #1 also had an order started on 05/15/24 to check O2 saturation every shift and if O2 was less than 89% then to notify MD/NP for new orders. Resident #1 also had an order started on 05/15/24 to document post nebulizer assessment of respiratory status and record treatment in 15 minutes every 12 hours and as needed.</p> <p>Record review of Resident #1's MAR, May 2024, revealed staff documented administering O2 at 2 liters by nasal cannula continuously every shift from 05/14/24 through 05/20/24. There were no other orders related to Resident #1's O2 listed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Daily Skilled Nurse's Notes, dated 05/14/24, 05/15/24, 05/16/24, 05/17/24, 05/18/24, 05/19/24 and 05/20/24, revealed staff assessed her respiratory status and she had normal breathing.</p> <p>An observation of Resident #1's room on 05/19/24 at 11:10 a.m. revealed Resident #1 was lying in bed. There was a wheelchair across from Resident #1's bed with an oxygen tank attached to the back of the wheelchair. The nasal cannula and tubing was hanging over one of the two wheelchair handles. The oxygen tank was not in use.</p> <p>During an interview on 05/19/24 at 11:10 a.m., Resident #1 revealed she last used the oxygen tank attached to the back of her wheelchair 3-4 days ago.</p> <p>An observation of Resident #1's room on 05/19/24 at 11:19 a.m. revealed CNA A walked into Resident #1's room to answer Resident #1's call light. CNA A completed Resident #1's request and walked out of Resident #1's room.</p> <p>During an interview on 05/19/24 at 11:26 a.m., CNA A revealed she checked on residents every hour or two hours. CNA A stated she documented the care and services she provided residents in residents' charts at the end or during her work shift. CNA A also stated nurses stored nasal cannula and tubing in a bag whenever an oxygen tank or machine was not in use. CNA A stated residents' health could be affected if tubing and nasal cannula were not stored away when the oxygen was not in use because residents could catch an infection. CNA A stated she did not notice Resident #1's tubing and nasal cannula for her oxygen tank were hanging over one of the two wheelchair handles .</p> <p>During an interview on 05/19/24 at 11:45 a.m., CNA B revealed she checked on residents every hour. CNA B stated she documented the care and services she provided residents in residents' charts after completing the care or service. CNA B also stated nurses stored nasal cannula and tubing in a bag whenever an oxygen tank or machine was not in use. CNA B stated residents' health could be affected if tubing and nasal cannula were not stored away when the oxygen was not in use because residents could catch an infection. CNA B did not notice Resident #1's tubing and nasal cannula for her oxygen tank were hanging over one of the two wheelchair handles.</p> <p>During an interview on 05/19/24 at 11:49 a.m., ADM revealed nursing staff checked on residents every two hours. ADM explained CNAs documented the care and services they provided residents in residents' charts and nurses documented in assessments and nurse's notes.</p> <p>During an interview on 05/19/24 at 12:55 p.m., PRN Nurse C revealed she checked on residents every two hours. PRN Nurse C stated she document the care and services she provided residents in residents' charts two hours before her work shift ends and whenever she was required to communicate with the NP and MD. PRN Nurse C did not know how the tubing and nasal cannula was to be stored whenever the oxygen machine and tank were not in use. PRN Nurse C stated residents' health could be affected if tubing and nasal cannula were not stored away when the oxygen was not in use because residents could catch an infection. PRN Nurse C also stated nurses should put tubing in the residents' wheelchair pocket when oxygen was not in use. PRN Nurse C stated she worked with Resident #1 in the morning of 05/19/24. PRN Nurse C did not notice Resident #1's tubing and nasal cannula for her oxygen tank were hanging over one of the two wheelchair handles.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/24 at 1:23 p.m., PRN RN D revealed residents' oxygen tubing and nasal cannula were stored in a bag whenever the oxygen machine or tank was not in use. PRN RN D explained the bag was changed out anytime the tubing and nasal cannula were taken out of the bag and used. PRN RN D stated residents could potentially be affected if oxygen tubing and nasal cannula were not properly stored away when oxygen was not in use.</p> <p>During an interview on 05/19/24 at 5:22 p.m., ADM revealed she was looking for the facility's Oxygen Use and Storage policy and procedure.</p> <p>During an interview on 05/20/24 at 10:14 a.m., the DON revealed she in-serviced staff on oxygen storage weekly by an online program. The DON stated she reviewed oxygen procedures with staff once weekly. The DON also stated nurses were supposed to store tubing and nasal cannula in a bag to protect the tubing and nasal cannula from dust. The DON stated the CNAs can notify the nurses when an oxygen machine or tank was not in use. The DON also stated residents could be affected if tubing and nasal cannula were not properly stored when oxygen machine or tank not in use.</p> <p>During an interview on 05/20/24 at 10:44 a.m., ADON revealed oxygen tubing and nasal cannula were stored in a bag when not in use. The ADON stated residents' health could be affected if oxygen tubing and nasal cannula were not stored in bag when not in use because it was an infection control issue.</p> <p>Record review of the facility's Respiratory Therapy Prevention of Infection policy and procedure, revised November 2011, revealed the following:</p> <p>Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff.</p> <p>Steps in the Procedure: Infection Control Considerations Related to Oxygen Administration:</p> <p>8. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.</p>