

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 07/09/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 routine and emergency drugs and biologicals for 1 of 4 residents (Resident #1) reviewed for pharmacy services.1. The facility failed to ensure Resident #1's ciprofloxacin-dexamethasone (antibiotic ear drops) was acquired and administered according to physician's orders. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life. Findings include:These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life. Findings include: Review of Resident #1 face sheet reflected a [AGE] year-old male admitted on [DATE] with diagnoses of impacted cerumen (earwax buildup), chronic atrial fibrillation (rapid or irregular heartbeat), anemia (condition where body does not have enough red blood cells to carry oxygen throughout the body), and abdominal aortic aneurysm (swelling in the main artery that carries blood from heart to abdomen).Review of physician orders for Resident #1 reflected ciprofloxacin-dexamethasone drops to be administered as four drops in left ear twice a day with a start date of 07/04/2025 through 07/09/2025. Review of prescription order for Resident #1 reflected order for ciprofloxacin-dexamethasone drops was received on 07/03/2025 to start on 07/04/2025 by LVN A. Review of Resident #1's baseline care plan dated 06/30/2025 reflected Resident #1 was alert/cognitively intact. Further review reflected resident was independent with transfers. Resident #1 required assistance of 1 staff with grooming and bathing. Review of the July 2025 MAR reflected Resident #1's ciprofloxacin-dexamethasone medication was not signed off/administered on 07/04/2025, 07/05/2025, 07/06/2025, 07/07/2025, 07/08/2025 and 07/09/2025. During an interview and observation on 07/09/2025 at 10:50 AM, Resident #1 stated his ear bled on 06/30/2025 and he was supposed to get medication for it on 07/04/2025 and on 07/05/2025 it was the weekend and someone told him he would have to wait for it until 07/07/2025. Resident #1 stated as of today (07/09/2025) he still has not received any medication for his ear. Resident #1 stated he had no pain or drainage continue, but he believed he should not have to wait this long for the medication. Resident #1 was observed with cotton in his year. There was no drainage or bleeding observed. Observation on 07/09/2025 at 1:58 PM, reflected there was no ciprofloxacin-dexamethasone ear drops available for Resident #1. During an interview on 07/09/2025 at 1:58 PM, MA B stated that Resident #1 does not have any ear drops available. She stated that the facility was not giving him any drops because he do not have the ear drops. MA B stated the ear drops have not come in. MA B stated that the ADON was supposed to put in any new orders. MA B stated she worked a few days and that she had not seen the ear drops for Resident #1. MA B stated she was supposed to tell the nurse if a medication was not available. MA stated she told the nurse last week, but she was unsure who the nurse was. During an interview on 07/09/2025 at 2:04 PM, LVN C stated that written or telephone orders may be on paper. LVN C stated that the nurse that received the order should have sent it to the pharmacy and the pharmacy delivered the medication. LVN C checked the medication cart and stated there was no ear drops available for Resident #1. LVN C reviewed Resident #1's ordered an confirmed there was an order for ciprofloxacin-dexamethasone. LVN C stated that she was not sure if medication was delivered on the holidays or weekends. LVN C stated that nurse managers was supposed to ensure that orders were put in. LVN C stated that if a medication was not available, first the nurse should have checked the e-kit and call pharmacy for an update and notify the on-coming nurse. LVN C stated that she was not made aware that the ear drops was not available today. LVN C stated that potential harm for not receiving antibiotic ear drops could be increased pain. LVN C stated that Resident #1 did not complain of pain today. During an interview on 07/09/2025 at 2:16 PM, the ADON stated that new orders taken by the nurse was handed off to nursing management to ensure they medications was put into the resident's chart. The ADON stated that the order was faxed to the pharmacy by the nurse. The ADON stated the next morning the new order would be reviewed. The ADON stated that 5:00 PM was the cut off and if medication order was not faxed by 5:00 PM the medication would not be delivered until the following day. Medications was also delivered on the weekends. The ADON stated that someone from nursing leadership was present on Saturday and Sunday as well. The ADON stated that if a medication had not been delivered the first option was to check the e-kit if the medication was available and if not the prescriber should have been notified</p>		