STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675918	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracy Woods Nursing Center	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** Based on interviews, 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 promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for 1 of 5 (Resident #1) residents observed for dignity. 1. The facility failed to ensure Resident #1 was clean while in the dining room being assisted with feeding. Resident #1 was in the dining room being fed with fecal matter on both of his hands. This failure could place residents at risk of experiencing humiliation, degradation, and a decreased quality of life.The findings included: Record review of Resident #1's face sheet dated 03/03/26, reflected a [AGE] year-old male admitted to the facility on [DATE]. The face sheet did not indicate active diagnoses. Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. Active diagnosis reflected progressive neurological conditions, hypertension (high blood pressure), viral hepatitis (inflammation of the liver), diabetes mellitus (condition when the body cannot properly use blood sugar or glucose), and non-Alzheimer's dementia (loss of memory and other intellectual functions severe enough to cause problems with ones abilities to perform usual personal, social, and occupational activities). Section GG for functional abilities reflected Resident #1 required substantial/ maximal assistance with both eating and personal hygiene. Record review of Resident #1's care plan last revised 02/11/26 reflected a focus potential for weight loss due to impaired cognitive functioning with dementia, difficulty with self-feeding 2nd to blindness/ visual loss, therapeutic diet that may not always be appealing to him interventions included ensure resident is clean, dry, and comfortable before meal time and provide assistance as needed for meal completion; resident requires substantial assistance for meal intake. An additional focus included resident requires assistance for ADL and mobility tasks due to impaired cognitive functioning with dementia, visual deficit with left eye blindness, generalized weakness, poor endurance/ activity tolerance, impaired balance, reduced ROM to bilateral shoulders with interventions that included resident requires maximum assistance for personal hygiene tasks. Record review of facility grievance report dated 02/27/26 reflected FM expressed concern r/t hand hygiene during meals. follow up documentation revealed residents hands cleaned immediately social worker present to resolve concern. Record review of Resident #1's progress notes dated 02/28/26 written by the ADM reflected, this writer was notified of the grievances related to this resident from family on Friday 02/27/2026. Family expressed concerns related to meal service. The social worker of the facility was present during the grievance resolution process at dinner on 02/27/2026 and ensured that the grievances by this residents [family member] was addressed promptly. During an interview on 03/03/26 at 11:56 AM, Resident #1's FM (family member) stated he arrived at the facility on Friday 02/27/26 in the evening during mealtime and went to the dining room to find Resident #1 being assisted with his meal. FM stated as he approached Resident #1's table, he smelled a foul odor that smelled like BM. He said when he arrived at the table, he could see Resident #1's hands which were at chest level and saw BM on both of his hands. FM stated he became extremely upset by this and (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	demanded that Resident #1 be cleaned up. FM stated the SW was still at the facility and the SW came to the dining room and witnessed Resident #1 in the condition he was in. The FM stated he was upset that Resident #1 was being fed with obvious fecal matter on his hands without staff cleaning him first. During an interview on 03/03/26 at 12:40 PM with Resident #1, he stated he could not recall the event in the dining room that occurred 02/27/26. During an interview on 03/03/26 at 03:12 PM, the SW stated he was at the facility the evening of Friday 02/27/26. He stated he was alerted of the complaint made by Resident #1's FM he went to the dining room and observed fecal matter on both of Resident #1's hands. The SW stated he was shocked and alarmed when he saw it, and it was upsetting to see that in the cafeteria. He stated Resident #1 had known behaviors of scratching himself and putting his hands in his pants. The SW stated he was surprised that Resident #1 was able to make it to the dining room without being cleaned. The SW stated he observed upon entry was that Resident #1 was being fed by CNA A. The SW stated he questioned CNA A about the fecal matter on Resident #1's hands and if he was aware of it, CNA A denied being aware of it. The SW stated he notified the ADM about the situation after ensuring Resident #1 was cleaned. The SW stated he could not understand how he [CNA A] could not see that. The residents hands were at chest level where he usually maintained them. The SW stated he did not smell the fecal matter but stated it was probably due to allergies and had he not had allergies he believed he would be able to smell it. The SW stated the amount of fecal matter on Resident #1's hands was enough to be noticed. The SW stated that Resident #1 was calm and did not recognize he had fecal matter, he was not crying, not upset, and only responded to the family member being upset asking why are you upset. The SW stated he was startled by the event and processing the event and reaction by the family member that he was not thinking about psychosocial effects and did not complete a psychosocial evaluation for Resident #1. He stated I dropped the ball, that evening or the next day I should've asked those questions. He stated he should've completed the psychosocial evaluation within 72 hours. He stated he saw Resident #1 that Saturday and he did not appear to have any adverse psychosocial effects. During an interview on 03/03/26 at 03:34 PM CNA A stated he was at the facility on 02/27/26 when the incident occurred and was the CNA assisting Resident #1 with his meal. He stated he did not assist the resident to the dining room and was not sure who did, but after he completed passing out meal trays he was to sit and assist those who needed meal assistance so he had sat down that day to assist Resident #1. CNA A stated he had been feeding Resident #1 for approximately 10 minutes before Resident #1's FM arrived at the table and alerted him to the BM on the residents hands. CNA A stated he had not noticed the BM on Resident #1's hands as the resident doesn't use his hands. CNA A stated he did not smell the BM on Resident #1's hands and stated it appeared it had already dried up so he believed that is why he did not smell it or take notice. He stated the expectation was that residents were groomed and cleaned prior to going to the dining room. He stated a negative outcome to residents having BM on their hands while being fed was infection control. CNA A stated when FM brought attention to the matter in the dining room Resident #1 was saying shut up to the FM and he believed it was due to Resident #1 being embarrassed by the situation. CNA A stated LVN B was in the dining room at the time and saw the situation and instructed for staff to clean the resident. During an interview on 03/03/26 at 04:07 PM, LVN B stated he worked the dining room on Friday 02/27/26. He said he assisted with dinner services as the nurse checking meal trays. LVN B stated he was alerted to the incident when he heard Resident #1's FM bring attention to it and saw CNA A feeding Resident #1 and Resident #1 having BM on his hands. LVN B stated he had instructed CNA A to clean Resident #1 and they used sanitizer wipes to clean his hands. LVN B stated a negative outcome to BM on residents hands during mealtime is infection control, he stated everyone wants to be clean, it can affect him psychosocially. LVN B stated that based on the residents behavior at the time he did not appear upset or negatively impacted. During an interview on 03/03/26 at 04:19 PM, the DON stated she was not in the facility when the incident occurred on Friday 02/27/26 but she was alerted to it the same day. She stated Resident #1 had known behaviors of putting his hands in his pants and getting fecal matter (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on his hands. The DON stated it was her expectation that residents were clean when they are were fed and stated this was an unfortunate situation. She stated a negative outcome was infection control and dignity issues. The DON stated there was no reported psychosocial effects at the time of the event. The DON stated they initiated training on expectations including hand hygiene and infection control but that training was still ongoing and there were still staff that had not completed training. During an interview on 03/03/26 at 04:55 PM, the ADM stated she became aware of the incident on the evening of 02/27/26, when it occurred via a phone call from the SW and advised that Resident #1 be cleaned immediately. She stated it was known of residents behavior related to putting his hands in his briefs and was care planned. The ADM stated the DON was working on re-educating staff in the facility and it was still ongoing because all staff had not received the training yet. She stated she was not aware of any negative outcome that occurred. She stated there was a potential for breach of infection control if he touched surfaces or food. Review of the facility Resident Rights policy revised December 2016 reflected: Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a dignified existence;be treated with respect, kindness, and dignity

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 1 of 5 residents (Resident #1) reviewed for infection control/sanitary environment. The facility failed to ensure staff performed hand hygiene for Resident #1 and fecal matter was removed from his hands prior to being fed in the dining room. This failure could place residents at risk for developing communicable diseases and infections.Findings included:Record review of Resident #1's face sheet dated 03/03/26 reflected a [AGE] year-old male admitted [DATE]. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Active diagnosis reflected progressive neurological conditions, hypertension (high blood pressure), viral hepatitis (inflammation of the liver), diabetes mellitus (condition when the body cannot properly use blood sugar or glucose), and non-Alzheimer's dementia (loss of memory and other intellectual functions severe enough to cause problems with ones abilities to perform usual personal, social, and occupational activities). Section GG for functional abilities reflected Resident #1 required substantial/ maximal assistance with both eating and personal hygiene. Record review of Resident #1's care plan last revised 02/11/26 reflected a focus potential for weight loss due to impaired cognitive functioning with dementia, difficulty with self-feeding 2nd to blindness/ visual loss, therapeutic diet that may not always be appealing to him interventions included ensure resident is clean, dry, and comfortable before meal time and provide assistance as needed for meal completion; resident requires substantial assistance for meal intake. An additional focus included resident requires assistance for ADL and mobility tasks due to impaired cognitive functioning with dementia, visual deficit with left eye blindness, generalized weakness, poor endurance/ activity tolerance, impaired balance, reduced ROM to bilateral shoulders with interventions that included resident requires maximum assistance for personal hygiene tasks. Record review of a facility grievance report dated 02/27/26 reflected FM expressed concern r/t hand hygiene during meals.on follow up the documentation revealed residents hands cleaned immediately social worker present to resolve concern. Record review of Resident #1's progress dated 02/28/26 written by the ADM reflected this writer was notified of the grievances related to this resident from family on Friday 02/27/2026. Family expressed concerns related to meal service. The social worker of the facility was present during the grievance resolution process at dinner on 02/27/2026 and ensured that the grievances by this resident's [family member] was addressed promptly. During an interview on 03/03/26 at 11:56 AM, Resident #1's FM (family member) stated he arrived at the facility on Friday 02/27/26 in the evening during mealtime and went to the dining room to find Resident #1 being assisted with his meal. FM stated that as he approached Resident #1's table he smelled a foul odor that smelled like BM. When he arrived at the table, he could see Resident #1's hands which were at chest level and could see BM on both of his hands. FM stated he became extremely upset by this and demanded that Resident #1 be cleaned up. FM stated the SW was still at the facility and he went to the dining room and also witnessed Resident #1 in the condition he was in. FM stated he was upset that Resident #1 was being fed with obvious fecal matter on his hands without staff cleaning him first. During an interview on 03/03/26 at 12:40 PM with Resident #1, he stated he could not recall the event in the dining room that occurred 02/27/26. During an interview on 03/03/26 at 03:12 PM with the SW, he stated he was at the facility the evening of Friday 02/27/26. He stated he was alerted of the complaint made by FM and went to the dining room and observed fecal matter on both of Resident #1's hands. SW stated he was shocked and alarmed when he saw it and it was upsetting to see that in the cafeteria. He stated Resident #1 had known behaviors of scratching himself and putting his hands in his pants but stated he was surprised that Resident #1 was able to make it to the dining room without being cleaned. SW stated he observed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon entry was that Resident #1 was being fed by CNA A. The SW stated upon getting to the table he questioned CNA A about seeing the fecal matter on Resident #1's hands and if he was aware of it, CNA A denied being aware of it. The SW stated he then notified the ADM about it right away after ensuring Resident #1 was cleaned. The SW stated that he could not understand how he [CNA A] could not see that. The residents hands were at chest level where he usually maintained them. The SW denied being able to smell the fecal matter but stated it was probably due to allergies and had he not had allergies he believed he would be able to smell it. The SW stated the amount of fecal matter on Resident #1's hands was enough to be noticed. During an interview on 03/03/26 at 03:34 PM with CNA A, he stated he was at the facility on 02/27/26 when the incident occurred and was the CNA assisting Resident #1 with his meal. CNA A stated he was already feeding Resident #1 and had been for approximately 10 minutes before Resident #1's FM had arrived at the table and alerted him to the BM on the residents hands. CNA A stated he had not noticed the BM on Resident #1's hands as the resident doesn't use his hands. CNA A denied there being a smell to the BM on Resident #1's hands and stated it appeared it had already dried up. He stated it was the expectation that residents were groomed and cleaned prior to going to the dining room. He stated a negative outcome to residents having BM on their hands while being fed was infection control. During an interview on 03/03/26 at 04:07 PM with LVN B stated he worked in the dining room on Friday 02/27/26 and was in the dining room assisting with dinner services as the nurse checking meal trays. LVN B stated he was alerted to the incident when he heard Resident #1's FM bring attention to it and saw CNA A feeding Resident #1 and Resident #1 having BM on his hands. LVN B stated he instructed CNA A to clean Resident #1's hands and sanitizer wipes were used to clean the resident's hands. LVN B stated a negative outcome to BM on residents hands during mealtime is infection control, he also stated everyone wants to be clean, it can affect him psychosocially. During an interview on 03/03/26 at 04:19 PM with the DON she stated she was not in the facility when the incident occurred on Friday 02/27/26 but she was alerted to it the same day. She stated Resident #1 has known behaviors of putting his hands in his pants and getting fecal matter on his hands. The DON stated it was the expectation that residents should be clean when they are being fed and stated this was an unfortunate situation. She stated a negative outcome was infection control and dignity issues. The DON stated they initiated training on expectations including hand hygiene and infection control, but that training was still ongoing and there were still staff that had not completed training. During an interview on 03/03/26 at 04:55 PM with the ADM, she stated she became aware of the incident on the evening of 02/27/26 when it occurred via a phone call from the SW and advised that Resident #1 be cleaned immediately. She stated that it was known of residents behavior related to putting his hands in his briefs and was care planned. The ADM stated the DON was working on re-educating staff in the facility and that it was still ongoing as not everyone had received the training yet. She stated she was not aware of any negative outcome that occurred. She stated there was a potential for breach of infection control if he touched surfaces or food.Review of the facility Infection Prevention and Control policy effective 11/28/17 reflected: Objective: To effectively investigate, control, and/or prevent infections. Responsible departments: All staff the facility shall investigate, control and/or prevent infections through implementation of an Infection Prevention & Control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.