

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  02/28/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39075</p> <p>Based on observations, interviews, and record reviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 5 of 24 resident rooms for Residents #69, #74, #31, #12, #15 whose rooms were observed for housekeeping and maintenance services.</p> <ol style="list-style-type: none"> <li>1. Resident #69's room did not have a pull string for the overhead light, the wall paper on the wall behind the head of the bed was peeling off, the cover to a drawer on the right bottom closet was missing, and the privacy curtain was torn from the top and the torn portion was used to tie the bottom of the curtain so it would not drag on the floor.</li> <li>2. The facility failed to provide a functional accessible bathroom and a functioning light switch with a plate cover in Resident #74's room.</li> <li>3. The facility failed to ensure room [ROOM NUMBER] did not have a broken base board, peeling wallpaper, and missing toilet tank top cover.</li> <li>4. The facility failed to ensure Resident #31's room did not have a privacy curtain with large stains.</li> <li>5. The facility failed to ensure Resident #12's room did not have broken blinds to provide full privacy and failed to replace a missing drawer at the bottom of the closet.</li> <li>6. The facility failed to ensure room [ROOM NUMBER] did not have frayed carpet at the threshold.</li> <li>7. The facility failed to ensure Resident #15's room did not have a large hole in the wall and no pull string for the overhead light.</li> </ol> <p>These deficient practices could place any residents at risk of living in an unclean and unsanitary environment and result in feelings of dissatisfaction.</p> <p>The findings were:</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #69's face sheet dated 2/26/25 revealed a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included acquired absence of right leg below the knee, diabetes (chronic medical condition that occurs when the body cannot produce effective insulin to regular blood sugars), muscle wasting, and malaise (general feeling of discomfort or weakness related to an underlying illness or condition).</p> <p>Record review of Resident #69's most recent annual MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required total dependence on staff for transfers.</p> <p>Record review of Resident #69's comprehensive care plan with revision date 2/3/25 revealed the resident was visually impaired for small print and required adequate lighting to assist with vision, and the resident had ADL deficit which made the resident dependent on transfer tasks.</p> <p>During an observation and interview on 2/25/25 at 9:28 a.m., Resident #69 was observed in their room sitting up in bed with the overhead light turned on over the head of the bed. Resident #69 stated the only thing he did not like about living in the facility was they don't fix anything. Resident #69 stated, the overhead light could not be turned on because the pull string was pulled off accidentally by a nurse aide, he was unable to identify. Resident #69's overhead light was observed without a pull string, and after further observation, the wall paper on the wall behind the head of the bed was peeling off, the cover to a drawer on the right bottom closet was missing, and the privacy curtain was torn from the top and the torn portion was used to tie the bottom of the curtain so it would not drag on the floor. Resident #69 stated the condition of the room had been like that since I've been here and I feel like they don't care. Resident #69 stated the only way to turn on the overhead light was for a staff to flip the switch from the wall at the entry of the bedroom. Resident #69 stated he was unable to get in and out of bed without staff assistance. Resident #69 stated I told all of them, and they say I'll write it on the book. Resident #69 stated he had talked to the Maintenance Manager about it and was told the facility did not have the parts.</p> <p>During an observation and interview on 2/27/25 at 1:26 pm, LVN A stated Resident #69 was an amputee and required staff assistance with transfers. LVN A stated, if a resident complained of broken stuff in a room, we have a maintenance book and write the resident room (on the book) and what was wrong and the maintenance book was at the nurse's station. LVN A stated the missing pull string from the overhead light had been reported to the Maintenance Director, but on observation revealed she had never noticed the peeling wallpaper on the wall behind the head of the bed or the missing cover to the drawer on the right bottom closet, or the torn privacy curtain. LVN A stated, if I lived in that room, I would not like it and if I'm sick and I wanted to use the light, I would have to rely on the staff to turn the light on for me, and I should be able to turn on the light by myself. I would not feel good about it. LVN A further stated she was not sure if the issue had been brought up to management.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 2/27/25 at 1:44 p.m., CNA C stated, when a resident complained of broken items in their room, she was trained to write it on the Maintenance Log. CNA C further stated, unless the issue was with a call light then the issue would be reported to the charge nurse because that would require immediate attention. On observation of Resident #69's room, CNA C stated she had provided care to Resident #69 and had been in the resident's room numerous times. CNA C stated, Resident #69 had reported to her about the pull string missing from the overhead light and stated, I may have put that in the (Maintenance) Book. I was aware of it. Upon further observation, CNA C stated she had not noticed the peeling wallpaper, but was aware of the torn privacy curtain, but was not sure if that had been reported. CNA C stated, if I lived in the room, it would not make me feel good. I would be frustrated not being able to turn on the light because I can't walk to the wall to turn on the overhead light.</p> <p>During an observation and interview on 2/27/25 at 2:44 p.m., the MM stated, if staff asked for something to be fixed, they were supposed to write it on the Maintenance Log. The MM stated he had not been in Resident #69's room and on observation noted the pull string from the overhead light was missing, the wallpaper was peeling off the wall, the drawer on the right bottom closet was missing the cover, and the torn privacy curtain. The MM stated, I see what you're saying, I'm sympathetic to (Resident #69's) feelings.</p> <p>2. Record review of Resident #74's face sheet dated 2/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness, spastic quadriplegic cerebral palsy (a severe condition that affects muscle control and movement in both arms and legs as well as the trunk of the body), and lack of coordination.</p> <p>Record review of Resident #74's most recent quarterly assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required total assistance with bed mobility and transfers.</p> <p>Record review of Resident #74's comprehensive care plan with revision date 6/18/24 revealed the resident required total assistance with ADL's.</p> <p>During an observation and interview on 2/25/25 at 11:28 a.m., Resident #74 was observed in their room with a missing light switch and plate cover that was supposed to be used to turn on the bathroom light. Further observation revealed inside the bathroom there was a high back wheelchair blocking the toilet. Resident #74 stated it bothered his family when they visited because there was no light switch to the bathroom and his family were unable to use the bathroom when they wanted to. Resident #74 stated the bathroom was used as storage.</p> <p>During an observation and interview on 2/27/25 at 2:01 p.m., CNA R stated Resident #74 often had the resident's family member visits the resident. On observation, CNA R stated she had noticed the equipment in the resident's bathroom and if the room needed repairs staff were supposed to report it in the Maintenance Log which was located at the nurse's station. CNA R stated she had put some things in the maintenance log but could not reveal if the missing light switch and plate cover had been reported. CNA R stated, I would not feel comfortable [living in Resident #74's room], I would want it fixed immediately or moved to another room. It's not ok, I would not like it, I would want it fixed immediately or move me.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 2/27/25 at 3:02 p.m., the MM stated he was aware of the missing light switch and plate cover in Resident #74's room, and was also aware of Resident #74's family member complaining about not being able to use the bathroom in the room. The MM stated, the concern had been made to him a week ago.</p> <p>3. During an observation on 2/27/25 at 10:00 a.m. room [ROOM NUMBER] had a baseboard on the floor. The wall was exposed with mesh and wall plaster. There was dried paint on the floorboards and cracked sheet rock under the window. Paint was peeling off the window seal trim. Wallpaper was peeling off the wall. The toilet had black stains. The tank of the toilet was missing a top and had a black ring around the top of the water tank.</p> <p>During an interview on 2/27/25 at 3:05 a.m. the MM stated he started working for the facility in January of 2025. The MM stated he had not gone around the building to look at rooms and see if anything needed to be worked on. The MM stated he was only assigned to the 200 hallway and was not sure who was assigned to the 400 hallway.</p> <p>4. During an observation and interview on 2/25/25 at 12:37 p.m. of Resident #31's room revealed the room had a privacy curtain with an approximately 2x2 ft yellowish stain with a streaked appearance and small solid particles stuck to the stain. A second stain small stain in the bottom center of the curtain was brownish and streaked. Resident #31 stated he had not paid attention to the stain, but his roommate Resident #72 would sometimes vomit.</p> <p>During an interview on 2/27/25 at 10:48 a.m. Housekeeper I stated she checked resident rooms to see if their privacy curtains were cleaned. Housekeeper I stated she did not know what the stains were. Housekeeper I stated she knew the privacy curtain in Resident #31's room had been dirty for about 3 days. She stated she would report it to her manager, and they would have the MM take it down to be cleaned.</p> <p>5. Record review of Resident #12's Admission record documented a [AGE] year-old female admitted to the facility on [DATE] for the latest return. Her diagnoses included a pressure ulcer of the right hip, chronic kidney disease (involves a gradual loss of kidney function and can cause fluid to build up in the body), Type 2 diabetes mellitus with diabetic neuropathy (a condition in which the body has trouble controlling blood sugar and using it for energy with a chronic loss of kidney function), peripheral vascular disease (a disease or disorder of the circulatory system that affects blood vessels), and Crohn's disease (a type of inflammatory bowel disease).</p> <p>Record review of Resident #12's quarterly MDS dated [DATE] documented a BIMS score of 12 indicating moderate cognitive impairment.</p> <p>Record review of Resident #12's Care Plan with an edited date of 02/03/25 documented the resident requires assistance for ADL and mobility tasks due to generalized weakness, poor endurance / activity tolerance, limited mobility and primarily bedbound state, end stage / terminal disease process. She has loss of ROM / contractures to bilateral (both) hands.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview with Resident #12 on 02/26/25 at 4:05 pm, revealed the blinds in the window were broken, and there was a drawer missing from the resident's closet. Resident #12 was asked if the broken blinds in her window and the missing drawer in the closet were an issue for her. Resident #12 stated they had been like that for a while but she was sure the facility was going to replace the blinds at some point. She said the blinds break when they try to straighten them out. Resident #12 was not sure when the facility would fix the drawer.</p> <p>6. During an observation of the hall on 02/26/25 at 4:15 pm, the carpet at the threshold of room [ROOM NUMBER] was badly frayed and could pose a trip hazard, however both residents residing in the room used wheelchairs for ambulation.</p> <p>7. Record review of Resident #15's Admission Record documented a [AGE] year-old male admitted to the facility 12/30/20. Resident #15's diagnoses included unspecified dementia (a syndrome characterized by a general decline in cognitive abilities involving memory, thinking, behavior and motor control), Type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with a chronic loss of kidney function), chronic atrial fibrillation (a condition that causes the heart to quiver and beat irregularly), chronic obstructive pulmonary disease (a progressive lung disease characterized by chronic respiratory symptoms and airflow limitation) and bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood).</p> <p>Record review of Resident #15's Quarterly MDS dated [DATE], documented a BIMS score of 11 indicating moderate cognitive impairment.</p> <p>During an observation and interview with Resident #15 on 02/26/25 at 4:23 pm, the resident stated there was a large hole behind his bed. Resident #15 stated he often has nightmares that something is coming out of the hole. Upon observation of the hole, the sheetrock in the wall was damaged and there was a hole approximately 12 in diameter where one could reach in between the studs in the wall. Resident #15 also could not turn on his overbed light since there was no string to pull on the light so the light could only be turned on with the switch at the entrance door.</p> <p>During an interview with RN II on 02/27/25 at 1:46 pm, RN II stated the facility was aware of the maintenance issues and the problems had been put in the Maintenance Log. RN II stated it was unknown when maintenance would address the issues.</p> <p>During an interview with LVN KK on 02/27/25 at 1:50 pm, LVN KK stated he had been here (facility) for 4 months and that he thought the rooms are all good with no problems. After showing him the hole in the wall for Resident #15, he was asked what he would do about it. LVN KK stated he would report it to the charge nurse who would then report it to the hierarchy.</p> <p>During an interview on 02/27/25 at 2:44 pm, MM was shown the various maintenance issues that had been discovered. MM stated he had only been here since January 2025 and was aware there were a lot of issues that needed to be addressed. MM stated that if staff finds an issue, they are supposed to put it in the Maintenance Log which he checks daily. MM stated if a resident tells me something is needed, I try to take care of it right away.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the ADM on 02/27/25 at 3:13 pm, she stated that everyone had access to the Maintenance Log and were aware it was located at the nurse's station. ADM also stated they did Guardian Angel Rounds where every manager was assigned to 4 rooms to check daily and any issues were reported in the morning meeting. ADM also stated that she did grand rounds with the DON, ADON and MM. The Administrator stated the MM had only been employed by the facility since January 2025 and the previous MM was full of lip service and there's a reason he is not here anymore. ADM stated, We are going to get rid of the carpet in the 20 rooms that still have carpet. We are trying to do better for the residents and try to get to repairs as timely as possible. The Administrator was asked by the State Surveyor how it would make her feel to live in a room that needed repair and she stated, I can't speak to that. The residents are not expressing to me about the aesthetics of their room. I only ask if they are doing ok.</p> <p>Record review of the facility's policy titled Quality of Life-Homelike Environment, revised 5/17, Policy Statement: residents are provided with a safe, clean, comfortable and home like environment and encouraged to use their personal belongings to the extent possible. 1. Staff shall provide person-centered care that emphasize the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflected personalized, home like setting. These characteristics include: a. Clean, sanitary and orderly environment .e. clean bed and bath linens that are in good condition .</p> <p>45857</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45857</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal for 1 of 8 residents (Resident #36) reviewed for grievances.</p> <p>The facility failed to fully investigate and address Resident #36's grievance report of missing personal property, including two computers, a wallet, DVDs, and food items, and did not assist Resident #36 in replacing his identification and bank card.</p> <p>This failure could place residents at risk for not having their grievances resolved.</p> <p>The findings included:</p> <p>Record review of Resident #36's continuity of care document (CCD), dated 2/28/25, revealed a [AGE] year-old male resident was admitted on [DATE] with diagnosis that included multiple sclerosis (a chronic autoimmune disease that affects the central nervous system), disorder of brain, and age-related physical debility.</p> <p>Record review of Resident #36's annual MDS assessment, dated 12/9/24, revealed his cognition was intact for daily decision making.</p> <p>A record review of Resident #36's care plan conference dated 12/11/2024 revealed, Resident #36 expressed desires to stay in facility long term.</p> <p>Record review of Resident #36's Release of Responsibility for leave of Absence form, dated 2024, revealed Resident #36 had not been signed out at all.</p> <p>Record review of a grievance report, dated 2/5/25, revealed the SW completed the form for Resident #36. The concern was missing laptop and wallet. It stated the laundry plus all staff were assigned the responsibility for the investigation. The findings of the investigation was blank. The plan to resolve the grievance was searched room and laundry for missing items. Expected results of actions taken was blank. Reportable to state agency was blank. Under post investigation follow up, grievance resolved? Yes or no was not check and stated Laptop was located. Will continue to search and remind staff to look for wallet. It stated the investigation results and resolution steps were verbally reported to the resident.</p> <p>Record review of invoice, dated 6/8/20, showed a 2018 Chromebook laptop was purchased for \$276.04 by Resident #36 and shipped to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of invoice, dated 6/12/21, showed a 2021 17.3 HP laptop with i7 processor and DVD player was purchased for \$1,222.14 by Resident #36 and shipped to the nursing facility. The order showed Return request approved (Return request approved typically means the customer is eligible to proceed with returning the item, but it does not necessarily mean a refund has been issued. The customer should follow the instructions provided to complete the return process, such as printing a return label or scheduling a pickup. If the item is not returned after the request is approved, the customer may not receive a refund.) at the top. It did not show the item was refunded (If your invoice says refunded, it means [retailer] has processed a refund for a returned item from your order).</p> <p>Record review of return information, dated 6/19/2021, revealed Resident #36 initiated a request to return the laptop purchased on 6/12/21 for \$1,222.14 on 6/19/2021. There was an option to print the mailing label or cancel the return.</p> <p>During an interview on 2/25/25 at 10:00 a.m. Resident #36 stated he had a form of autism. Resident #36 stated in December of 2024 he was forced out of his room because they found bed bugs on his roommate. He stated he was not allowed to remove any items from his room and was moved to a room on another hallway. He stated when he returned to his room in 2025 it looked like it had been ransacked. He stated two of his laptops were missing, his wallet was missing, some DVDs were missing, and a box of snacks. He stated he reported the missing items to the facility and filed a report with the police. He stated the facility had not to found or replaced his missing items.</p> <p>During an interview on 2/26/25 at 2:43 p.m. LVN B stated nursing staff would complete an inventory sheet for each resident that is admitted to the facility wither they had personal items or not. LVN B stated there was no inventory sheet found for Resident #36. LVN B tried to find an example of an inventory sheet and pulled charts for two other residents, and they also did not have inventory sheets in their charts.</p> <p>During an interview on 2/26/25 at 3:05 p.m. QA E stated staff would receive a packet to fill out when they received a new admission resident. QA E stated there was a check list that managers would go over the next day and the inventory sheet was included in the check list. QA E stated there was no inventory sheet found for Resident #36.</p> <p>During an interview on 2/27/25 at 4:54 p.m. The DON stated Resident #36 had been at the facility for many years. The DON stated they normally complete an inventory sheet on admission, if the resident brings in more items, they need to report it and add it to the inventory sheet, and on discharge staff will also complete an inventory sheet. The DON stated she only knew of Resident #36 having one laptop. The DON stated she heard he was missing a laptop and wallet and staff had looked for the items.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/25 at 5:17 p.m. the SW stated Resident #36 reported to her that he had 4 laptops, but she only thought he had 2 laptops. The SW stated she did not have an inventory sheet for Resident #36. The SW stated inventory sheets are normally done on admission. The SW stated she did not think to complete an inventory sheet after he filed the grievance, but it was a good thing to start doing. The SW stated Resident #36 did not show her any receipts for items he had purchased, and she did not ask for any receipts. The social worker stated they had looked for the wallet in the laundry but did not find it. The SW stated she continued to remind staff to look for Resident #36's wallet. The SW stated she thought his wallet contained his ID card and bank card. The SW was asked if she had tried to help the resident replace his ID card or bank card and she stated she had not but could help him. The SW stated she did not have any family involvement and had not seen any visitors for Resident #36. The SW stated it was up to the Administrator if they would replace any missing items and she needed permission from corporate.</p> <p>During a follow up interview on 2/27/25 at 5:23 p.m. Resident #36 stated his missing wallet had his ID card, a checking card, and about \$15 or \$16 in it. He stated he purchased the missing laptops through an online retailer and had receipts. He pulled up the order summaries on his laptop. One laptop was a 2018 Samsung 11.6-inch Chromebook purchased on 6/8/20 for \$276.04. He stated this was the first laptop he purchased after being admitted to the nursing facility because he need one with Wi-Fi capabilities. Later he stated he liked to watch DVDs and needed a computer with a DVD player. He showed another order summary for a 2021 HP 17.3 laptop with a DVD player purchased on 6/12/21 for \$1,222.14. He stated a couple of DVDs were also missing and some snacks he purchased online too. He stated he was able to cancel his bank card but was not able to check his bank account to see if anyone had used the card because the bank log in wanted him to use a 2-step verification with a phone number he no longer had in service. He stated he needed help with replacing his ID and bank card and needed to make a trip to the bank.</p> <p>During an interview on 2/27/25 at 5:52 p.m. the Administrator stated Resident #36 initially reported he was only missing one laptop and his wallet. The Administrator stated the number of missing laptops had grown in number each time he reported it. The Administrator stated she thought his wallet had been bundled up with the laundry and they had not finished washing everything. The Administrator stated no one had seen him with 2 laptops. The Administrator stated the facility had been his primary residence since 2020 and she had never seen anyone visit him. The Administrator stated she believed one family member mailed him things or possibly visited him at night because she never saw the family member. The Administrator stated if the resident left the facility at anytime it would be recorded on the Release of Responsibility for leave of Absence form located at the front desk. The Administrator stated the resident had told her on 2/27/25 he stated he had sent back a laptop. The Administrator stated Resident #36 had not expressed how he wanted her to resolve the missing items. The Administrator stated they could help him contact his bank and speak to management about replacing the missing items because typically they are not liable. The Administrator stated when he moved rooms they let him take one laptop.</p> <p>During an observation on 2/27/25 at 6:06 p.m. Resident #36 had a laptop on his dresser and a laptop in a drawer in his room. Both laptops in his room were different models than the other 2 laptops shown on the invoices.</p> <p>(continued on next page)</p>		

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 2/28/25 at 10:10 a.m. LVN B stated when a resident had to leave their room due to bed bugs they were not allowed to remove any items from the room. LVN B stated they did this for any residents who had a possible bed bug infestation. LVN B stated Resident #36 was moved to another room on a different hallway and there was a TV on the wall already in the new temporary room he was assigned. LVN B stated she had caught Resident #36 trying to sneak into his old room to remove items and told him to stay out of his old room. LVN B stated she never observed Resident #36 with a computer in the new temporary room.</p> <p>During an interview on 2/28/25 at 11:04 a.m. CNA F stated Resident #36 was very independent and sensitive about staff touching any of his belongings. CNA F stated she was only aware of the one computer he had out on his dresser and used. CNA F stated he may have had other computers in the drawers in his room. CNA F stated she had worked at the facility for many years and had never met or seen any visitors for Resident #36. CNA F stated she knew Resident #36 always had his own personal snacks and thought they might be delivered to him by mail. CNA F stated Resident #36 would let you know if he needed anything and never had complaints. CNA F stated when Resident #36 reported he had missing items after he was allowed to return to his room, she believed him because he never complained of missing items in all the previous years at the facility.</p> <p>During a follow up interview on 2/28/25 at 2:26 p.m. the Administrator stated she went to speak to Resident #36 and look at the invoice receipts for his two missing laptops. The Administrator stated the laptop purchased on 6/12/21 for \$1,222.14 showed it was returned and they would not replace it because it said it was returned. The Administrator stated they planned to replace the \$276.04 laptop purchased on 6/8/20, some DVDs, and assist with replaced his identification cards and bank card. The Administrator stated Resident #36 told the SW he wanted all the missing items replaced. The Administrator stated they had now given the resident a list to complete for what snacks he liked. The Administrator stated the blank on the policy should say 14 days, they had 14 days to investigate a grievance. The Administrator stated they did not report the allegation of misappropriation of property because she did not believe it was misappropriation because the resident did not say his items were stolen but said they were missing. The Administrator said the resident would have had to use the words stolen for her to report it to the state agency. The Administrator stated because the Resident had changing stories, they also planned to have him seen by psychiatric services.</p> <p>During a follow up interview on 2/28/25 at 2:52 p.m. Resident #36 stated on 6/19/21 he tried to return the laptop purchased on 6/12/21 for \$1,222.14. He stated he asked one of the nursing facility staff members to help him with the return because he did not understand the instructions and could not print a return label. Resident #36 stated that staff member told him to follow the instructions for the return and send him the return label and he would print it out. The Resident stated he needed help with the whole return process and was never able to return the laptop.</p> <p>Record review of the facility policy titled Grievances/Complaints, Recording and investigating, dated 3/2017, stated Policy Statement All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy Interpretation and Implementation 1. The Administrator has assigned the responsibility of investigating grievances and complaints to the Grievance Officer. 2. Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the allegations. 3. The department director(s) of any named employee(s) will be notified of the nature of the complaint and that an investigation is underway. he investigation and report will include, as applicable:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. The date and time of the alleged incident;</p> <p>b. The circumstances surrounding the alleged incident;</p> <p>c. The location of the alleged incident;</p> <p>d. The names of any witnesses and their accounts of the alleged incident;</p> <p>e. The resident's account of the alleged incident;</p> <p>f. The employee's account of the alleged incident;</p> <p>g. Accounts of any other individuals involved (i.e., employee's supervisor, etc.); and</p> <p>h. Recommendations for corrective action.</p> <p>The Grievance Officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The following information will be recorded and maintained in the log:</p> <p>a. The date the grievance/complaint was received;</p> <p>b. The name and room number of the resident filing the grievance/complaint (if available);</p> <p>c. The name and relationship of the person filing the grievance/complaint on behalf of the resident (if available);</p> <p>d. The date the alleged incident took place;</p> <p>e. The name of the person(s) investigating the incident;</p> <p>f. The date the resident, or interested party, was informed of the findings; and</p> <p>g. The disposition of the grievance (i.e., resolved, dispute, etc.).</p> <p>6. The Resident Grievance/Complaint Investigation Report Form will be filed with the Administrator within five (5) working days of the incident.</p> <p>7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ____ working days of the filing of the grievance or complaint.</p> <p>8. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law.</p> <p>9. A copy of the Resident Grievance/Complaint Investigation Report Form must be attached to the Resident Grievance/Complaint Form and filed in the business office.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from Misappropriation of property for one (Resident #36) of 8 residents reviewed for misappropriation of property.</p> <p>The facility failed to ensure Resident #36 was free from misappropriation of property when he was forced to leave his room and belongings after a bed bug infestation and when he returned his wallet, DVDs, snacks, and two laptops were missing.</p> <p>This failure could place residents at risk of Exploitation/Misappropriation of Property and financial distress.</p> <p>Findings include:</p> <p>Record review of Resident #36's continuity of care document (CCD), dated 2/28/25, revealed a [AGE] year-old male resident was admitted on [DATE] with diagnosis that included multiple sclerosis (a chronic autoimmune disease that affects the central nervous system), disorder of brain, and age-related physical debility.</p> <p>Record review of Resident #36's annual MDS assessment, dated 12/9/24, revealed his cognition was intact for daily decision making.</p> <p>A record review of Resident #36's care plan conference dated 12/11/2024 revealed, Resident #36 expressed desires to stay in facility long term.</p> <p>Record review of Resident #36's Release of Responsibility for leave of Absence form, dated 2024, revealed Resident #36 had not been signed out at all.</p> <p>Record review of Bed Bug Service Report, dated 12/19/24, revealed a room on the 400 hallway was treated and one live bed bug was found on a curtain.</p> <p>Record review of a grievance report, dated 2/5/25, revealed the SW completed the form for Resident #36. The concern was missing laptop and wallet. It stated the laundry plus all staff were assigned the responsibility for the investigation. The findings of the investigation was blank. The plan to resolve the grievance was searched room and laundry for missing items. Expected results of actions taken was blank. Reportable to state agency was blank. Under post investigation follow up, grievance resolved? Yes or no was not check and stated Laptop was located. Will continue to search and remind staff to look for wallet. It stated the investigation results and resolution steps were verbally reported to the resident.</p> <p>Record review of invoice, dated 6/8/20, showed a 2018 Chromebook laptop was purchased for \$276.04 by Resident #36 and shipped to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of invoice, dated 6/12/21, showed a 2021 17.3 HP laptop with i7 processor and DVD player was purchased for \$1,222.14 by Resident #36 and shipped to the nursing facility. The order showed Return request approved (Return request approved typically means the customer is eligible to proceed with returning the item, but it does not necessarily mean a refund has been issued. The customer should follow the instructions provided to complete the return process, such as printing a return label or scheduling a pickup. If the item is not returned after the request is approved, the customer may not receive a refund.) at the top. It did not show the item was refunded (If your invoice says refunded, it means [retailer] has processed a refund for a returned item from your order).</p> <p>Record review of return information, dated 6/19/2021, revealed Resident #36 initiated a request to return the laptop purchased on 6/12/21 for \$1,222.14 on 6/19/2021. There was an option to print the mailing label or cancel the return.</p> <p>During an interview on 2/25/25 at 10:00 a.m. Resident #36 stated he had a form of autism. Resident #36 stated in December of 2024 he was forced out of his room because they found bed bugs on his roommate. He stated he was not allowed to remove any items from his room and was moved to a room on another hallway. He stated when he returned to his room in 2025 it looked like it had been ransacked. He stated two of his laptops were missing, his wallet was missing, some DVDs were missing, and a box of snacks. He stated he reported the missing items to the facility and filed a report with the police. He stated the facility had not to found or replaced his missing items.</p> <p>During an interview on 2/26/25 at 2:43 p.m. LVN B stated nursing staff would complete an inventory sheet for each resident that is admitted to the facility wither they had personal items or not. LVN B stated there was no inventory sheet found for Resident #36. LVN B tried to find an example of an inventory sheet and pulled charts for two other residents, and they also did not have inventory sheets in their charts.</p> <p>During an interview on 2/26/25 at 3:05 p.m. QA E stated staff would receive a packet to fill out when they received a new admission resident. QA E stated there was a check list that managers would go over the next day and the inventory sheet was included in the check list. QA E stated there was no inventory sheet found for Resident #36.</p> <p>During an interview on 2/27/25 at 4:54 p.m. The DON stated Resident #36 had been at the facility for many years. The DON stated they normally complete an inventory sheet on admission, if the resident brings in more items, they need to report it and add it to the inventory sheet, and on discharge staff will also complete an inventory sheet. The DON stated she only knew of Resident #36 having one laptop. The DON stated she heard he was missing a laptop and wallet and staff had looked for the items.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/27/25 at 5:17 p.m. the SW stated Resident #36 reported to her that he had 4 laptops, but she only thought he had 2 laptops. The SW stated she did not have an inventory sheet for Resident #36. The SW stated inventory sheets are normally done on admission. The SW stated she did not think to complete an inventory sheet after he filed the grievance, but it was a good thing to start doing. The SW stated Resident #36 did not show her any receipts for items he had purchased, and she did not ask for any receipts. The social worker stated they had looked for the wallet in the laundry but did not find it. The SW stated she continued to remind staff to look for Resident #36's wallet. The SW stated she thought his wallet contained his ID card and bank card. The SW was asked if she had tried to help the resident replace his ID card or bank card and she stated she had not but could help him. The SW stated she did not have any family involvement and had not seen any visitors for Resident #36. The SW stated it was up to the Administrator if they would replace any missing items and she needed permission from corporate.</p> <p>During a follow up interview on 2/27/25 at 5:23 p.m. Resident #36 stated his missing wallet had his ID card, a checking card, and about \$15 or \$16 dollars in it. He stated he purchased the missing laptops through an online retailer and had receipts. He pulled up the order summaries on his laptop. One laptop was a 2018 Samsung 11.6-inch Chromebook purchased on 6/8/20 for \$276.04. He stated this was the first laptop he purchased after being admitted to the nursing facility because he needed one with Wi-Fi capabilities. Later he stated he liked to watch DVDs and needed a computer with a DVD player. He showed another order summary for a 2021 HP 17.3 laptop with a DVD player purchased on 6/12/21 for \$1,222.14. He stated a couple of DVDs were also missing and some snacks he purchased online too. He stated he was able to cancel his bank card but was not able to check his bank account to see if anyone had used the card because the bank log in wanted him to use a 2-step verification with a phone number he no longer had in service. He stated he needed help with replacing his ID and bank card and needed to make a trip to the bank.</p> <p>During an interview on 2/27/25 at 5:52 p.m. the Administrator stated Resident #36 initially reported he was only missing one laptop and his wallet. The Administrator stated the number of missing laptops had grown in number each time he reported it. The Administrator stated she thought his wallet had been bundled up with the laundry and they had not finished washing everything. The Administrator stated no one had seen him with 2 laptops. The Administrator stated the facility had been his primary residence since 2020 and she had never seen anyone visit him. The Administrator stated she believed one family member mailed him things or possibly visited him at night because she never saw the family member. The Administrator stated if the resident left the facility at anytime it would be recorded on the Release of Responsibility for leave of Absence form located at the front desk. The Administrator stated the resident had told her on 2/27/25 he stated he had sent back a laptop. The Administrator stated Resident #36 had not expressed how he wanted her to resolve the missing items. The Administrator stated they could help him contact his bank and speak to management about replacing the missing items because typically they are not liable. The Administrator stated when he moved rooms they let him take one laptop.</p> <p>During an observation on 2/27/25 at 6:06 p.m. Resident #36 had a laptop on his dresser and a laptop in a drawer in his room. Both laptops in his room were different models than the other 2 laptops shown on the invoices.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 2/28/25 at 10:10 a.m. LVN B stated when a resident had to leave their room due to bed bugs they were not allowed to remove any items from the room. LVN B stated they did this for any residents who had a possible bed bug infestation. LVN B stated Resident #36 was moved to another room on a different hallway and there was a TV on the wall already in the new temporary room he was assigned. LVN B stated she had caught Resident #36 trying to sneak into his old room to remove items and told him to stay out of his old room. LVN B stated she never observed Resident #36 with a computer in the new temporary room.</p> <p>During an interview on 2/28/25 at 11:04 a.m. CNA F stated Resident #36 was very independent and sensitive about staff touching any of his belongings. CNA F stated she was only aware of the one computer he had out on his dresser and used. CNA F stated he may have had other computers in the drawers in his room. CNA F stated she had worked at the facility for many years and had never met or seen any visitors for Resident #36. CNA F stated she knew Resident #36 always had his own personal snacks and thought they might be delivered to him by mail. CNA F stated Resident #36 would let you know if he needed anything and never had complaints. CNA F stated when Resident #36 reported he had missing items after he was allowed to return to his room, she believed him because he never complained of missing items in all the previous years at the facility.</p> <p>During a follow up interview on 2/28/25 at 2:26 p.m. the Administrator stated she went to speak to Resident #36 and look at the invoice receipts for his two missing laptops. The Administrator stated the laptop purchased on 6/12/21 for \$1,222.14 showed it was returned and they would not replace it because it said it was returned. The Administrator stated they planned to replace the \$276.04 laptop purchased on 6/8/20, some DVDs, and assist with replaced his identification cards and bank card. The Administrator stated Resident #36 told the SW he wanted all the missing items replaced. The Administrator stated they had now given the resident a list to complete for what snacks he liked. The Administrator stated the blank on the policy should say 14 days, they had 14 days to investigate a grievance. The Administrator stated they did not report the allegation of misappropriation of property because she did not believe it was misappropriation because the resident did not say his items were stolen but said they were missing. The Administrator said the resident would have had to use the words stolen for her to report it to the state agency. The Administrator stated because the Resident had changing stories, they also planned to have him seen by psychiatric services.</p> <p>During a follow up interview on 2/28/25 at 2:52 p.m. Resident #36 stated on 6/19/21 he tried to return the laptop purchased on 6/12/21 for \$1,222.14. He stated he asked one of the nursing facility staff members to help him with the return because he did not understand the instructions and could not print a return label. Resident #36 stated that staff member told him to follow the instructions for the return and send him the return label and he would print it out. The Resident stated he needed help with the whole return process and was never able to return the laptop.</p> <p>Record review of the facility policy titled Grievances/Complaints, Recording and investigating, dated 3/2017, stated .8. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law .</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled Abuse Investigation and Reporting, stated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . 4. The investigator, if other than the Administrator, will consult daily with the Administrator concerning the progress/findings of the investigation. 5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to all appropriate agencies and authorities as designated by regulations. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than . b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</b></p> <p>Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Abuse Coordinator for 1 (Resident #36) of 8 residents reviewed for abuse.</p> <p>The facility failed to report to the state agency when Resident #36 alleged his wallet, DVDs, snacks, and two laptops were missing.</p> <p>This failure could place residents at risk of Exploitation/Misappropriation of Property and financial distress.</p> <p>Findings include:</p> <p>Record review of Resident #36's continuity of care document (CCD), dated 2/28/25, revealed a [AGE] year-old male resident was admitted on [DATE] with diagnosis that included multiple sclerosis (a chronic autoimmune disease that affects the central nervous system), disorder of brain, and age-related physical debility.</p> <p>Record review of Resident #36's annual MDS assessment, dated 12/9/24, revealed his cognition was intact for daily decision making.</p> <p>A record review of Resident #36's care plan conference dated 12/11/2024 revealed, Resident #36 expressed desires to stay in facility long term.</p> <p>Record review of Resident #36's Release of Responsibility for leave of Absence form, dated 2024, revealed Resident #36 had not been signed out at all.</p> <p>Record review of Bed Bug Service Report, dated 12/19/24, revealed a room on the 400 hallway was treated and one live bed bug was found on a curtain.</p> <p>Record review of a grievance report, dated 2/5/25, revealed the SW completed the form for Resident #36. The concern was missing laptop and wallet. It stated the laundry plus all staff were assigned the responsibility for the investigation. The findings of the investigation was blank. The plan to resolve the grievance was searched room and laundry for missing items. Expected results of actions taken was blank. Reportable to state agency was blank. Under post investigation follow up, grievance resolved? Yes or no was not check and stated Laptop was located. Will continue to search and remind staff to look for wallet. It stated the investigation results and resolution steps were verbally reported to the resident.</p> <p>Record review of invoice, dated 6/8/20, showed a 2018 Chromebook laptop was purchased for \$276.04 by Resident #36 and shipped to the nursing facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of invoice, dated 6/12/21, showed a 2021 17.3 HP laptop with i7 processor and DVD player was purchased for \$1,222.14 by Resident #36 and shipped to the nursing facility. The order showed Return request approved (Return request approved typically means the customer is eligible to proceed with returning the item, but it does not necessarily mean a refund has been issued. The customer should follow the instructions provided to complete the return process, such as printing a return label or scheduling a pickup. If the item is not returned after the request is approved, the customer may not receive a refund.) at the top. It did not show the item was refunded (If your invoice says refunded, it means [retailer] has processed a refund for a returned item from your order).</p> <p>Record review of return information, dated 6/19/2021, revealed Resident #36 initiated a request to return the laptop purchased on 6/12/21 for \$1,222.14 on 6/19/2021. There was an option to print the mailing label or cancel the return.</p> <p>During an interview on 2/25/25 at 10:00 a.m. Resident #36 stated he had a form of autism. Resident #36 stated in December of 2024 he was forced out of his room because they found bed bugs on his roommate. He stated he was not allowed to remove any items from his room and was moved to a room on another hallway. He stated when he returned to his room in 2025 it looked like it had been ransacked. He stated two of his laptops were missing, his wallet was missing, some DVDs were missing, and a box of snacks. He stated he reported the missing items to the facility and filed a report with the police. He stated the facility had not to found or replaced his missing items.</p> <p>During an interview on 2/26/25 at 2:43 p.m. LVN B stated nursing staff would complete an inventory sheet for each resident that is admitted to the facility wither they had personal items or not. LVN B stated there was no inventory sheet found for Resident #36. LVN B tried to find an example of an inventory sheet and pulled charts for two other residents, and they also did not have inventory sheets in their charts.</p> <p>During an interview on 2/27/25 at 4:54 p.m. The DON stated Resident #36 had been at the facility for many years. The DON stated they normally complete an inventory sheet on admission, if the resident brings in more items, they need to report it and add it to the inventory sheet, and on discharge staff will also complete an inventory sheet. The DON stated she only knew of Resident #36 having one laptop. The DON stated she heard he was missing a laptop and wallet and staff had looked for the items.</p> <p>During an interview on 2/27/25 at 5:17 p.m. the SW stated Resident #36 reported to her that he had 4 laptops, but she only thought he had 2 laptops. The SW stated she did not have an inventory sheet for Resident #36. The SW stated inventory sheets are normally done on admission. The SW stated she did not think to complete an inventory sheet after he filed the grievance, but it was a good thing to start doing. The SW stated Resident #36 did not show her any receipts for items he had purchased, and she did not ask for any receipts. The social worker stated they had looked for the wallet in the laundry but did not find it. The SW stated she continued to remind staff to look for Resident #36's wallet. The SW stated she thought his wallet contained his ID card and bank card. The SW was asked if she had tried to help the resident replace his ID card or bank card and she stated she had not but could help him. The SW stated she did not have any family involvement and had not seen any visitors for Resident #36. The SW stated it was up to the Administrator if they would replace any missing items and she needed permission from corporate.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 2/27/25 at 5:23 p.m. Resident #36 stated his missing wallet had his ID card, a checking card, and about \$15 or \$16 dollars in it. He stated he purchased the missing laptops through an online retailer and had receipts. He pulled up the order summaries on his laptop. One laptop was a 2018 Samsung 11.6-inch Chromebook purchased on 6/8/20 for \$276.04. He stated this was the first laptop he purchased after being admitted to the nursing facility because he need one with Wi-Fi capabilities. Later he stated he liked to watch DVDs and needed a computer with a DVD player. He showed another order summary for a 2021 HP 17.3 laptop with a DVD player purchased on 6/12/21 for \$1,222.14. He stated a couple of DVDs were also missing and some snacks he purchased online too. He stated he was able to cancel his bank card but was not able to check his bank account to see if anyone had used the card because the bank log in wanted him to use a 2-step verification with a phone number he no longer had in service. He stated he needed help with replacing his ID and bank card and needed to make a trip to the bank.</p> <p>During an interview on 2/27/25 at 5:52 p.m. the Administrator stated Resident #36 initially reported he was only missing one laptop and his wallet. The Administrator stated the number of missing laptops had grown in number each time he reported it. The Administrator stated she thought his wallet had been bundled up with the laundry and they had not finished washing everything. The Administrator stated no one had seen him with 2 laptops. The Administrator stated the facility had been his primary residence since 2020 and she had never seen anyone visit him. The Administrator stated she believed one family member mailed him things or possibly visited him at night because she never saw the family member. The Administrator stated if the resident left the facility at anytime it would be recorded on the Release of Responsibility for leave of Absence form located at the front desk. The Administrator stated the resident had told her on 2/27/25 he stated he had sent back a laptop. The Administrator stated Resident #36 had not expressed how he wanted her to resolve the missing items. The Administrator stated they could help him contact his bank and speak to management about replacing the missing items because typically they are not liable. The Administrator stated when he moved rooms they let him take one laptop.</p> <p>During an observation on 2/27/25 at 6:06 p.m. Resident #36 had a laptop on his dresser and a laptop in a drawer in his room. Both laptops in his room were different models than the other 2 laptops shown on the invoices.</p> <p>During a follow up interview on 2/28/25 at 10:10 a.m. LVN B stated when a resident had to leave their room due to bed bugs they were not allowed to remove any items from the room. LVN B stated they did this for any residents who had a possible bed bug infestation. LVN B stated Resident #36 was moved to another room on a different hallway and there was a TV on the wall already in the new temporary room he was assigned. LVN B stated she had caught Resident #36 trying to sneak into his old room to remove items and told him to stay out of his old room. LVN B stated she never observed Resident #36 with a computer in the new temporary room.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/28/25 at 11:04 a.m. CNA F stated Resident #36 was very independent and sensitive about staff touching any of his belongings. CNA F stated she was only aware of the one computer he had out on his dresser and used. CNA F stated he may have had other computers in the drawers in his room. CNA F stated she had worked at the facility for many years and had never met or seen any visitors for Resident #36. CNA F stated she knew Resident #36 always had his own personal snacks and thought they might be delivered to him by mail. CNA F stated Resident #36 would let you know if he needed anything and never had complaints. CNA F stated when Resident #36 reported he had missing items after he was allowed to return to his room, she believed him because he never complained of missing items in all the previous years at the facility.</p> <p>During a follow up interview on 2/28/25 at 2:26 p.m. the Administrator stated she went to speak to Resident #36 and look at the invoice receipts for his two missing laptops. The Administrator stated the laptop purchased on 6/12/21 for \$1,222.14 showed it was returned and they would not replace it because it said it was returned. The Administrator stated they planned to replace the \$276.04 laptop purchased on 6/8/20, some DVDs, and assist with replaced his identification cards and bank card. The Administrator stated Resident #36 told the SW he wanted all the missing items replaced. The Administrator stated they had now given the resident a list to complete for what snacks he liked. The Administrator stated the blank on the policy should say 14 days, they had 14 days to investigate a grievance. The Administrator stated they did not report the allegation of misappropriation of property because she did not believe it was misappropriation because the resident did not say his items were stolen but said they were missing. The Administrator said the resident would have had to use the words stolen for her to report it to the state agency. The Administrator stated because the Resident had changing stories, they also planned to have him seen by psychiatric services.</p> <p>During a follow up interview on 2/28/25 at 2:52 p.m. Resident #36 stated on 6/19/21 he tried to return the laptop purchased on 6/12/21 for \$1,222.14. He stated he asked one of the nursing facility staff members to help him with the return because he did not understand the instructions and could not print a return label. Resident #36 stated that staff member told him to follow the instructions for the return and send him the return label and he would print it out. The Resident stated he needed help with the whole return process and was never able to return the laptop.</p> <p>Record review of the facility policy titled Grievances/Complaints, Recording and investigating, dated 3/2017, stated .8. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled Abuse Investigation and Reporting, stated All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . 4. The investigator, if other than the Administrator, will consult daily with the Administrator concerning the progress/findings of the investigation. 5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to all appropriate agencies and authorities as designated by regulations. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than . b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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> 39075</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 5 of 21 residents (Resident #13, #31, #70, #69, and #74) reviewed for care plans:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Residents #13's Care Plan reflected they refused staff assistance with their personal refrigerated items.</li> <li>2. The facility failed to ensure Residents #31's Care Plan reflected they refused staff to assist with their personal refrigerated items.</li> <li>3. The facility failed to ensure Residents #70's Care Plan reflected they refused staff to assist with their personal refrigerated items.</li> <li>4. The facility failed to revise Resident #69's comprehensive care plan to reflect the resident no longer received a puree textured diet or crushed medications.</li> <li>5. The facility failed to revise Resident #74's comprehensive care plan to reflect the resident had a DNR status and did not utilize a colostomy.</li> </ol> <p>These deficient practices could cause confusion for staff members responsible for providing direct care to the residents and medication administration and place residents at risk of receiving improper care and services.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #13's CCD, dated [DATE], revealed a [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental disorder characterized variously by hallucinations (typically, hearing voices), delusions, disorganized thinking and behavior, and flat or inappropriate affect.), convulsions (a medical condition where the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking.), type 2 diabetes (a long-term condition where the body doesn't use insulin well and has too much sugar circulating in the blood.), major depressive disorder, and insomnia(is a common sleep disorder in which you have trouble falling and/or staying asleep.).</li> </ol> <p>Record review of Resident #13's quarterly MDS assessment, dated [DATE], revealed Resident #13's cognition was severely impaired for daily decision making.</p> <p>Record review of the Resident #13's Care Plan, dated [DATE], last revised [DATE] revealed he required a mechanically altered diet and monitor and record intake of food. The care plan did not mention the resident refused assistance with his personal refrigerator.</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 - Some</p>	<p>Record review of Resident #13's refrigerator temperature record, no date, was blank.</p> <p>During an observation on [DATE] at 10:05 a.m. of Resident #13's room revealed the room had a personal refrigerator for Resident #13. The fridge was stocked full of milk cartons from the kitchen.</p> <p>2. Record review of Resident #31's CCD, dated [DATE], revealed a [AGE] year-old male resident was admitted to the facility on [DATE] [DATE] with diagnoses including cerebral infarction ([NAME] the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), nausea, adult failure to thrive, type 2 diabetes (a long-term condition where the body doesn't use insulin well and has too much sugar circulating in the blood.), anxiety, and insomnia.</p> <p>Record review of Resident #31's quarterly MDS assessment, dated [DATE], revealed Resident #31's cognition was intact for daily decision making. Re-direct resident when potential for injury is evident.</p> <p>Record review of the Resident #31's Care Plan, dated [DATE], last revised [DATE] revealed the resident was unable to make daily decisions without cues/supervision R/T cognition that fluctuates over the course of the day d/t CVA (cardiovascular accident, commonly known as a stroke related to blood flow interrupted or reduced, depriving brain tissue of oxygen and nutrients). The care plan did not mention the resident refused assistance with his personal refrigerator.</p> <p>Record review of Resident #31's refrigerator temperature record, dated February 2025, had a recorded temperature and initials on the 17th and 18th. Nothing was recorded in the corrective actions space. The rest of the days were blank.</p> <p>During an observation on [DATE] at 12:37 p.m. of the personal refrigerator for Resident #31. Inside the fridge was a sandwich not in a container appeared to be hard. A open Styrofoam bowl of dried spaghetti and a meatball with green spots on it, several yellow and brown stains on the bottom of the fridge, a juice box that was half stained brown, a white plastic container with an unknown food dated best by [DATE].</p> <p>During an interview on [DATE] at 9:58 a.m. CNA G stated sometimes the check the resident refrigerators but sometimes they did not want you to check them.</p> <p>During an interview on [DATE] at 10:00 a.m. LVN H stated night shift would normally check the resident refrigerators. LVN H stated she had never made sure they were being checked by the night staff. LVN H stated they kept some logs behind the nurse's station. LVN H showed two logs for Resident #81 and Resident #78. LVN H stated they should attempt to help the resident clean out their fridge, so they do not get sick. LVN H stated she would try to get the residents to let her clean their refrigerators. LVN H stated Resident #31 would not let staff touch the items in his refrigerator, she did not think he would eat the expired and moldy food in the fridge, and the resident would sometimes tell staff to stay back when trying to provide him care.</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 - Some</p>	<p>3. Record review of Resident #70's CCD, dated [DATE], last reviewed and revised [DATE] revealed a [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive heart disease, edema, chronic obstructive pulmonary disease (a lung condition caused by damage to the airways), obesity, repeated falls, bipolar II (a mood disorder on the bipolar spectrum, characterized by at least one episode of hypomania and at least one episode of major depression. ), insomnia (is a common sleep disorder in which you have trouble falling and/or staying asleep.), and generalized anxiety disorder (is a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things.).</p> <p>Record review of Resident #70's quarterly MDS assessment, dated [DATE], revealed Resident #70's cognition was intact for daily decision making.</p> <p>Record review of the Resident #70's Care Plan, dated [DATE], revealed Resident is independent for ADL and mobility task. Resident is mobile using walker. He is independent for locomotion / ambulation in room / hallway / on and off the unit. The care plan did not mention the resident's behaviors of storing many cold food items on his dresser and bed outside of the refrigerator.</p> <p>Resident #70 did not have a personal refrigerator temperature record log.</p> <p>During an observation on [DATE] at 9:53 a.m. of the personal refrigerator for Resident #70, there were many containers of lunch meat on a dresser and in the resident's bed. Some of the containers of lunch meat had green spots. On a bedside table were numerous bottles with liquid stains on the outside of them.</p> <p>During an interview on [DATE] at 12:38 p.m. Resident #70 stated staff did not help him discard of food items in his room or check the refrigerator in his room. He stated he preferred to do it himself.</p> <p>During an interview on [DATE] at 4:13 p.m. the DON stated during daily round management staff was assigned to specific rooms and should be checking resident refrigerators. The DON stated some of the residents are head strong, so they have to be creative in how they approach them for assistance. The DON stated they should have it care planned if the resident has a personal refrigerator to show they are doing what they need to for their care and document they are refusing the help.</p> <p>During an interview on [DATE] at 9:55 a.m. the MDS nurse stated she was working on improving residents care plans because the facility had already identified it was an issue. The MDS nurse stated she had overlooked care planning refusals for help with personal refrigerators for Resident #31 and Resident #70. The MDS nurse stated she was not aware that Resident #13 would also refuse. The MDS nurse stated although the residents refused staff should still try to encourage the residents to discard old food items and keep them clean. The MDS nurse said they can also educate the residents on the risk of old food. The MDS nurse said if the behaviors were care planned and the resident had a stomach pain, they would know to make the doctor aware it maybe from the old food they are storing.</p> <p>4. Record review of Resident #69's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dysphagia-orpharyngeal phase (difficulty swallowing due to dysfunction in the mouth and throat), and vitamin deficiency.</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 - Some</p>	<p>Record review of Resident #69's most recent annual MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and complained of difficulty or pain with swallowing and received a mechanically altered diet.</p> <p>Record review of Resident #69's Order Summary Report dated [DATE] to [DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- DIET/CONSISTENCY: Mechanical Soft nectar thick liquids with order date [DATE] and no stop date</li> <li>- MEDICATIONS CRUSHED IN PUREE with order date [DATE] and no stop date</li> <li>- THICKENED LIQUIDS: NECTAR with order date [DATE] and no stop date</li> </ul> <p>Record review of Resident #69's Speech Therapy SLP Discharge Summary, dated [DATE] revealed the following:</p> <p>Discharge Recommendations:</p> <ul style="list-style-type: none"> <li>- Solids Diet Recs - Solids = Any/all oral intake</li> <li>- Liquids Diet Recs - Liquids = All Liquids</li> <li>- Strategies Comp Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquids/solids, rate modification, bolus size modifications and general swallow techniques/precautions upright posture during meals</li> <li>- Supervision - Supervision for Oral intake = Occasional supervision</li> <li>- D/C Recs - Discharge Recommendations: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquids/solids, rate modification, bolus size modifications and general swallow techniques/precautions upright posture during meals</li> <li>- Restorative Programs - Restorative Program Established/Trained = Not indicated at This Time\</li> <li>- Functional Maintenance - Functional Maintenance Program Established/Trained = Not Indicated at This Time</li> </ul> <p>Record review of Resident #69's physician's telephone order, dated [DATE] revealed the following orders:</p> <ul style="list-style-type: none"> <li>- Diet clarification: Regular, thin</li> </ul> <p>Record review of Resident #69's physician's telephone order, dated [DATE] revealed the following orders:</p> <ul style="list-style-type: none"> <li>- 1. DC Skilled ST Services</li> </ul> <p>(continued on next page)</p>		

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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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 2. Medications whole as tolerated.</p> <p>Record review of Resident #69's comprehensive care plan with revision date [DATE] incorrectly revealed the resident required medications be crushed and mixed into puree textures/consistencies as ordered for the next 90 days and the resident had a potential for dehydration due to mechanically altered diet/liquid textures/consistencies with approaches to provide fresh water at bedside thickened to appropriate consistency in easy reach and in manageable cup.</p> <p>During an observation and interview on [DATE] at 7:57 a.m., during the medication pass, MA D crushed 5 of Resident #69's morning pills. MA D stated Resident #69 took his medications crushed and received thickened liquids. MA D poured a thickened liquid into a cup and mixed the crushed pills with pudding. MA D used a paper MAR placed in a binder with the resident's medication orders on it and a blue sheet was observed in the binder filed with the resident's MAR which indicated, CRUSH MEDS &amp; NECTAR THICK LIQUIDS. MA D then attempted to administer Resident #69 his crushed medications with a thickened fluid and the resident refused to take them. Resident #69 stated, I do not take thickened water, look I have regular water, and the resident pointed to a glass of water with a straw in it that appeared to be thin in consistency. MA D asked the resident where he got the glass of water and the resident stated, I have been eating regular food and water a year now and I passed that test already. MA D left the bedside with the medications and thickened fluid and summoned LVN A.</p> <p>During an observation and interview on [DATE] at 8:29 a.m., LVN A stated she read Resident #69's physician's orders and determined if the resident could tolerate whole pills, he could have them. LVN A instructed MA D to discard Resident #69's crushed medications and dispense the medications whole.</p> <p>During an observation and interview on [DATE] at 4:06 p.m., SLP LL stated a Med Aide who she did not know had just asked her about Resident #69 and whether the resident could take whole pills and regular fluids. SLP LL stated she had not assessed the resident but went to interview the resident and he expressed wanting a regular textured diet and whole pills. SLP LL then provided this State Surveyor with telephone orders dated [DATE] with a diet clarification for regular diet and thin liquids and a telephone order dated [DATE] with an order to discontinue speech therapy and to administer medications whole as tolerated.</p> <p>During an interview on [DATE] at 4:05 p.m., the DON stated Resident #69 admitted to the facility already taking medications crushed and pureed meals. The DON stated, approximately three months prior Resident #69 had requested taking his medications whole instead of crushed and he had been evaluated by the SLP and it was determined he was safe to take whole pills. The DON stated, we realize and recognize we have a problem. I won't lie, we still have care plans that have not been updated. The DON further stated, care plans needed to be accurate because it tells you (the staff) how to care for the patient, and how to provide basic needs. The DON stated, MDS nurses are responsible for updating the care plan, we have had serious issues with care plans. The care plan should be changed as soon as the order is changed.</p> <p>5. Record review of Resident #74's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness, spastic quadriplegic cerebral palsy (a severe condition that affects muscle control and movement in both arms and legs as well as the trunk of the body), and lack of coordination. Further review of Resident #74's face sheet revealed, on the top section of the face sheet was the residents name and DNR next to the resident's name which indicated the resident had a Do Not Resuscitate code status.</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 - Some</p>	<p>Record review of Resident #74's most recent quarterly assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, had an external urinary catheter and was always incontinent of bowel. The MDS did not indicate the resident had a colostomy. Record review of the Significant Change MDS assessment dated [DATE] revealed the resident was always incontinent of bladder and the Bowel Incontinence section was checked, Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days look back.</p> <p>Record review of Resident #74's Physician Order Report dated [DATE] - [DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- CODE STATUS: FULL CODE with start date [DATE] and no stop date. Further review of the Physician Order Report revealed on the top section of the report was Resident #74's name and next to the name, DNR in parenthesis.</li> <li>- Further review of Resident #74's Physician Order Report dated [DATE] to [DATE] revealed the resident had an indwelling urinary catheter with orders to provide catheter care every shift but did not include orders for care of a colostomy.</li> </ul> <p>Record review of Resident #74's comprehensive care plan, with revision date [DATE] revealed the resident had a Full Code status and approaches that included to discuss code status and options with the resident at routine intervals and as needed. Further review of the comprehensive care plan revealed, the top of the document had the resident's name and in parenthesis DNR next to the resident's name. Further review of Resident #74's comprehensive care plan revealed the resident had urinary incontinence with the potential for UTI and had a colostomy with the potential for constipation. The comprehensive care plan included, under approaches, to provide colostomy care as needed.</p> <p>During an interview on [DATE] at 9:47 a.m., Resident #74 stated he used to be a full code but after consulting with his family, and because of the severe contractures to the lower extremities, it was best to be a DNR because it would be almost impossible to initiate CPR.</p> <p>During an interview on [DATE] at 10:39 a.m., LVN KK stated, code status was determined by referring to the resident's medical record binder and on the first page of the binder would be a green page indicating the resident was a full code or a red page indicating the resident was a DNR, and there would be an order in the chart. LVN KK stated, Resident #74 used to be a full code but recently he and his family changed to DNR status. LVN KK stated, the management team developed the comprehensive care plans. LVN KK stated she was not involved in any care plan meeting, but at morning meetings the management team would discuss any changes made to a resident's plan. LVN KK stated Resident #74 used to use a condom catheter but had recently changed to an indwelling catheter due to the condom catheter easily dislodging. LVN KK further stated, Resident #74 did not have a colostomy and never had one as far as she knew. LVN KK stated she had been working for the facility for approximately 6 months. LVN KK stated the management team were involved in developing a comprehensive care plan but when she had participated in the morning meeting, the management team would discuss any changes made to a resident's plan.</p> <p>During an interview on [DATE] at 11:40 a.m., the DON stated, any physician's orders uploaded into the electronic records should reflect current orders as of present day.</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 - Some</p>	<p>During an observation and follow up interview on [DATE] at 4:31 p.m., the DON stated, after reviewing Resident #74's Physician Order Report, revealed the resident had DNR orders but the resident was care planned as a full code. The DON stated, Resident #74 is on hospice, he used to be full code. They go back and forth, the resident and his family, but he is currently DNR. the DON stated, Resident #74 did not have a colostomy but could not elaborate or explain why it was included in the resident's care plan.</p> <p>During an interview on [DATE] at 9:44 a.m., the MDS Coordinator stated the care plan was done by a lot of people. The MDS Coordinator further stated she had only been the MDS Coordinator for the past 3 months and she had been working without help for the past month. The MDS Coordinator stated the facility did not have a lot of care plans in place, a lot of them were missing. It is a work in progress. The MDS Coordinator further stated, obviously I had not audit Resident #74's care plan. The MDS Coordinator stated the care plan determined how to guide the staff to take care of the patient. The MDS Coordinator stated, I should have updated the care plan.</p> <p>Record review of the facility's policy titled Personal Food Storage, dated 2013, Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety. Procedure: individuals will be educated on food safe handling and storage techniques by designated facility staff are needed. Staff will examine food for quality (visual, smell, packages close preferences to identify potential concerns. 2. Staff will provide information on safe food storage and handling as deemed appropriate. (For suggestions, see resources: who safety for your left one on the following page) 3. Designated facility staff will be assigned to monitor individual room storage and refrigeration units or beverage disposal, using the tips of the resources: food safety for your loved ones (on following page). 4. All refrigeration units will have the internal thermometer to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperature (see refrigeration and freezer temperature sample forms in this section.)</p> <p>Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated ,d+[DATE], stated A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .8. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment .g. incorporate identified problem areas; h. incorporate risk factors associated with identified problems; i. build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. reflect treatment goals, timetables and objectives in measurable outcomes; .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition changes .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39075</p> <p>Based on the observations, interviews, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 2 (Resident #47, and Resident #70) of 21 residents reviewed for accidents.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #47 did not have an insulin needle on her bedside table.</li> <li>2. The facility failed to ensure Resident #70 did not have a power strip in his room and a fan plugged into it.</li> </ol> <p>This failure could place the resident at risk of hazards and/or accidents.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #47's CCD 2/28/25, documented a [AGE] year-old female admitted to facility's secure unit on 10/19/24 with diagnoses, type 2 diabetes mellitus (a chronic health condition that affects how the body turns food into energy), depression, hypothyroidism (when the thyroid gland doesn't make enough thyroid hormone), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities ).</li> </ol> <p>Record review of Resident #47's Care Plan with Date Initiated 2/27/25, reviewed 2/2/25 revealed Resident has dx of diabetes mellitus. Administer medications: insulin as ordered by MD Evaluate/record/report effectiveness/adverse side effects.</p> <p>Record review of Resident #47's Quarterly MDS dated [DATE] revealed her cognition was intact for daily decision making.</p> <p>Observation and interview on 2/27/25 at 10:17 a.m. Resident #47 had a pen needle for an insulin pen unopened on her dresser. Resident #47 stated staff gave her the needle and she had it in her purse then put it on her dresser.</p> <p>During an interview on 2/27/25 at 4:38 p.m. the DON stated Residents needed an assessment to see if they could self-administer medications. She stated they would have it care planned and there would be a doctor's order. The DON stated the facility staff should be administering all medications to the residents. The DON stated no Resident should be self-administering insulins, staff should report immediately if a resident has prohibited items because it could put their life at risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #70's CCD, dated 2/28/25, revealed a [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive heart disease, edema (swelling), chronic obstructive pulmonary disease (a lung condition caused by damage to the airways), obesity, repeated falls, bipolar II (a mood disorder on the bipolar spectrum, characterized by at least one episode of hypomania and at least one episode of major depression.), insomnia (is a common sleep disorder in which you have trouble falling and/or staying asleep.), and generalized anxiety disorder (is a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things.).</p> <p>Record review of Resident #70's quarterly MDS assessment, dated 10/2/24, revealed Resident #70's cognition was intact for daily decision making.</p> <p>Record review of the Resident #70's Care Plan, dated 2/26/25, revealed Potential for falls due to history of repeat falls, history of pain and cardiovascular, neuroleptic and psychotropic medication administration. Floor clean and dry and clutter free environment.</p> <p>During an observation and interview on 2/25/25 at 9:53 a.m. Resident #70 had a power strip on the floor with a fan plugged into it. The resident stated he needed the fan because his room would get hot sometime. The resident stated they would tell staff it was hot but there was a delay in the facility staff adjusting the temperature.</p> <p>During a follow up observation and interview on 2/28/25 at 11:50 a.m. resident #70's power strip was still in his room. The Administrator stated she knew the resident should not have the power strip and had taken them away previously, but the resident will just have another one delivered to the facility.</p> <p>Record review of facility's document titled Personal Items allowable and non-allowable, no date, The following items are not permitted because they are controlled by codes, standards, regulations . to have an adverse effect on the health and safety of the resident .razors .extension cords, power strips, multi outlet adapters .</p> <p>45857</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</b></p> <p>Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 2 residents (Resident #21) reviewed for dialysis:</p> <p>The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #21.</p> <p>This failure could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs.</p> <p>The findings included:</p> <p>Record review of Resident #21's face sheet, dated 2/28/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included type 2 diabetes (chronic condition in which the body become resistant to insulin or doesn't produce enough insulin to maintain normal glucose levels), and chronic kidney disease stage 5 (also known as end stage renal disease; when the kidneys have lost nearly all of their function and treatment includes dialysis or kidney transplant).</p> <p>Record review of Resident #21's most recent quarterly MDS assessment, dated 2/2/25 revealed the resident was cognitively intact for daily decision-making skills, was always continent of bowel and bladder, and required dialysis treatments.</p> <p>Record review of Resident #21's Physician Order Report, dated 2/1/25 to 2/28/25 revealed the following:</p> <ul style="list-style-type: none"> <li>- DOCUMENT THRILL/BRUIT OF RIGHT AV SHUNT (arteriovenous shunt for dialysis; thrill and bruit refer to physical findings that indicate the shut is functioning properly) Q SHIFT, Every Shift, DAY, EVENING, NIGHT, with order date 10/31/23 and no stop date</li> <li>- SEND TO DIALYSIS ON TU, TH, AND SAT, with order date 12/6/23 and no stop date</li> <li>- NO BLOOD PRESSURE OR NEEDLESTICKS ON RIGHT ARM WITH AV SHUNT, Every Shift; DAY, EVENING, NIGHT, with order date 12/7/23 and no stop date</li> <li>- MONITOR RIGHT AV SHUNT FOR SIGNS AND SYMPTOMS OF INFECTION Q SHIFT, DAY, EVENING, NIGHT, with order date 1/15/25 and no stop date</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #21's comprehensive care plan, with edit date 2/5/25 revealed, under the Urinary Incontinence category, the resident was continent of bowel and bladder, had chronic kidney disease stage 5 and required renal dialysis. Further review of the comprehensive care plan, under the Urinary Incontinence category, under approaches revealed the staff were to document thrill/bruit of right AV shunt every shift, no blood pressure or needle sticks to the resident's right arm with AV shunt, and to ensure the resident went to dialysis treatments on Tuesday/Thursday/Saturday as scheduled.</p> <p>Record review of Resident #21's dialysis communication sheets revealed there were 3 sections to the form. The top section indicated, This section to be completed by Nursing Home Staff and sent with Resident to Dialysis Center. The middle section indicated, This section to be completed by Dialysis Staff and returned to Nursing Facility. The bottom section indicated, This section to be completed by Nursing Home Staff upon resident return and placed in clinical record. Record review of the dialysis communication sheets for Resident #21 filed in the resident's paper chart for the month of February 2025 revealed the following:</p> <ul style="list-style-type: none"> <li>- 2/1/25 bottom section was blank</li> <li>- 2/4/25 top and bottom section were blank</li> <li>- 2/6/25 bottom section was blank</li> <li>- 2/8/25 middle and bottom section were blank</li> <li>- 2/11/25 bottom section was blank</li> <li>- 2/13/25 bottom section was blank</li> <li>- 2/15/25 sheet was not provided</li> <li>- 2/18/25 sheet was not provided</li> <li>- 2/20/25 sheet was not provided</li> <li>- 2/22/25 sheet was not provided</li> <li>- 2/25/25 sheet was not provided</li> <li>- 2/27/25 sheet was not provided</li> </ul> <p>An attempt at an interview on 2/25/25 at 9:19 a.m., revealed Resident #21 was unable or unwilling to be interviewed and could not give any information regarding dialysis treatments.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 2/28/25 at 10:32 a.m., LVN A stated Resident #21 had dialysis treatments on Tuesdays, Thursdays and Saturdays and the last dialysis treatment occurred on 2/27/25. LVN A stated she was responsible for preparing the dialysis communication sheets which Resident #21 took with him when he went to dialysis. LVN A went to Resident #21's room and searched in a bag that was attached to the resident's wheelchair. LVN A stated the binder which held the dialysis communication sheet was missing and would get back with the surveyor with more information.</p> <p>During an interview on 2/28/25 at 11:03 a.m., CNA C stated she was familiar with Resident #21 and stated the resident went to dialysis treatments on Tuesdays, Thursdays, and Saturdays. CNA C stated, Resident #21 was given a pink binder that was placed in a bag strapped to the back of the resident's wheelchair but did not know what was in the pink binder. CNA C stated she did not have anything to do with the papers that were in the binder or the pink binder.</p> <p>During an observation and interview on 2/28/25 at 11:08 a.m., the DON stated, Resident #21 had dialysis treatments every Tuesday, Thursday and Saturday and the resident was given a dialysis folder to take with him every visit. The DON stated, the dialysis folder had a dialysis communication sheet with information from the facility that include his vital signs, any changes to medications, lab results or any changes to his physical health. The DON further stated, after the resident returned from dialysis, the dialysis clinic was supposed to complete a portion of the dialysis communication sheet, but often the dialysis communication sheet was not returned, or the dialysis clinic would not fill out their portion of the sheet. The DON stated, if the dialysis clinic did not fill in their portion of the dialysis communication sheet, it was the nurse's responsibility to call the dialysis clinic to obtain the information. The DON stated she checked the communication sheets after each dialysis visit and further stated, I want to see it, I check it (dialysis communication sheet). The DON showed the State Surveyor a cubby hole located at the nurse's station, marked DON and stated that was where nursing was supposed to put the dialysis communication sheets after the resident returned from dialysis treatment. The DON stated, once I review them (dialysis communication sheet) and satisfied with it, it is then filed in the resident's paper chart. The DON could not locate the dialysis communication sheet for the dialysis treatment visit on 2/27/25 for Resident #21 and stated she would get back with the State Surveyor.</p> <p>During an interview on 2/28/25 at 11:13 a.m., LVN B stated, Resident #21 did not come back with the dialysis communication sheet after the dialysis treatment on 2/27/25. LVN B stated, this is not the first time the communication sheet is forgotten. LVN B further stated, the dialysis communication sheets were supposed to be placed in the cubby hole marked, DON and every nurse knows that. LVN B stated, since Resident #21 is going back to the dialysis clinic tomorrow (3/1/24), then we will get the one from yesterday (2/27/25). LVN B stated, nursing prepared a new communication sheet every time the resident went to dialysis and the nurses included the resident's weight, blood pressure reading and document any new medications, or if there was any problem with the shunt site or if the resident was taking an antibiotic. LVN B stated, the dialysis clinic was supposed to fill in their portion of the dialysis communication sheet and send the form back to the nursing facility. LVN B stated, once the dialysis communication sheet came back, the facility nursing staff were responsible for obtaining the resident's vital signs again and assess the resident and document that on the dialysis communication sheet and then put it in the box for the DON. LVN B stated, if the dialysis clinic did not complete their portion of the form, the facility nurse was supposed to reach out to the dialysis clinic and report to the DON. LVN B stated, the dialysis communication sheets were important for the health of the resident and to note any change of condition.</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 - Few</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> 39075</p> <p>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 each resident for 2 of 8 residents (Residents #69 and #66) reviewed for medications and pharmacy services:</p> <ol style="list-style-type: none"> <li>1. MA D prepared Resident #69's medications and allowed LVN A to administer them to the resident.</li> <li>2. The facility failed to ensure LVN J administered all of Resident #66's arginine-based powder mixture (designed to support the unique nutritional needs of people with chronic wounds. It delivers 4.5 grams of L-arginine and Vitamins C and E for wound management.) via his PEG tube (is a surgery to place a feeding tube. Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach.)</li> </ol> <p>These deficient practices could put residents at risk for inaccurate or inappropriate administration of medications.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #69's face sheet dated 2/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included embolism and thrombosis of deep veins of right upper extremity (the formation of a blood clot in the deep veins which can potentially break loose and travel to other parts of the body which can cause swelling, pain, and impaired circulation to the affected limb), vitamin deficiency, hypertension (high blood pressure), and anemia (a deficiency in red blood cells that leads to oxygen delivery to tissues).</li> </ol> <p>Record review of Resident #69's most recent annual MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.</p> <p>Record review of Resident #69's Physician Order Report dated 2/1/25 to 2/28/25 revealed the following:</p> <ul style="list-style-type: none"> <li>- Aspirin chewable tablet 81 mg once a day with start date 7/8/24 and no stop date</li> <li>- Daily Multi vitamin with minerals one tablet once a day with start date 3/28/24 and no stop date</li> <li>-Lisinopril 20 mg tablet once a day with start date 7/28/24 and no stop date</li> <li>-Vitamin C 500 mg twice a day with start date 3/28/24 and no stop date</li> </ul> <p>(continued on next page)</p>		

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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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 2/26/25 at 7:57 a.m., during the medication pass, revealed MA D removed the Aspirin chewable tablet 81 mg, the Daily Multi vitamin with minerals tablet, the Lisinopril 20 mg tablet, and the Vitamin C 500 mg tablet from the medication blister pack and/or bottle, placed them in a medication cup and prepared to dispense to Resident #69. When MA D entered Resident #69's room, the resident was observed refusing the medications from MA D. MA D then passed the medication cup with Resident #69's pills to LVN A who was at the bedside to assist. LVN A then took the medication cup with Resident #69's pills and administered them to Resident #69.</p> <p>During an interview on 2/26/25 at 8:29 a.m., LVN A stated she was next to MA D and the State Surveyor when MA D was preparing Resident#69's medications and stated, I was standing here when she (MA D) was showing you (The State Surveyor) the medications. LVN A could not recite what medications MA D had administered to Resident #69. LVN A further stated, I should not have given the medications that I did not draw up, I don't know what is given, it might be a wrong medication, wrong dose. But this one I was standing there, you (The State Surveyor) were asking her (MA D), so I was watching her and listening.</p> <p>During an interview on 2/27/25at 7:45 p.m., the DON stated, if the medication aide was pulling medications, and the aides nurse supervisor could verify what medication the medication aide pulled and knew what medication was being given, I would be ok with giving the medication for the medication aide. The DON further stated, it was her expectation for the person who pulled the medication to dispense it but if the supervisor verified the medication then it would be ok for the supervisor to give it.</p> <p>2. Record review of Resident #66's CCD, dated 2/28/25, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), gastrostomy status (presence of an artificial opening in the stomach), pressure ulcer of unspecified part of back stage 4, protein calorie malnutrition, anemia (where there are insufficient healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood).</p> <p>Record review of Resident #66's quarterly MDS assessment, dated 12/23/24 revealed his cognition was intact for daily decision making.</p> <p>Record review of Resident #66's care plan, dated 2/27/25, revealed a problem area for Resident now has 1 stage 4 to left Ischium, right calf PAD, right toes 2nd-4th PAD right Ischium is closed as of 2/11/25, perineum MASD, right lateral malleolus PAD. Left Heel, Upper back are closed. He is at risk for additional skin breakdown due to dependence for management of all needs, weakness, poor endurance / activity tolerance, bedbound state, NPO status dependent on staff delivered G-Tube Feeding, presence of G-Tube, indwelling Foley Catheter, Colostomy, Protein-Calorie Malnutrition . Follow nutrition and hydration interventions as outlined .</p> <p>Record review of resident #66's physician orders, dated 2/27/25, revealed an order for arginine-vitamin c-vitamin e powder in packet; 4.5 gram-156 mg/9.2-gram, amount 1 packet via g-tube with a start date of 11/11/24 and no end date.</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 - Few</p>	<p>During an observation on 2/27/25 between 6:50 p.m. and 7:39 p.m. LVN J administered medication via Resident #66's peg tube. LVN J opened poured the arginine-vitamin c-vitamin e powder packet in a cup and added water to the cup. LVN J then drew up 60 mls of the arginine water mixture and administered it through the resident's peg tube. LVN J then drew up 30 mls of the arginine mixture and administered it through the resident's peg tube. LVN J then flushed the peg tube with 20 mls of tap water. 15 mls of the arginine mixture was left in the cup and LVN J discarded it.</p> <p>During an interview on 2/27/25 at 7:40 p.m. LVN J stated the left over 15 mls of the arginine mixture was just water. LVN J stated it was yellow color liquid, but it was just the end of the arginine, and she would discard it.</p> <p>During an interview on 2/27/25 at 7:43 p.m. the DON stated all of the mixed medicine should be administered to the resident for therapeutic effect.</p> <p>Record review of the facility policy titled Administering Medications, revised 4/19, stated medications are administered in a safe and timely manner, and as prescribed .1. Only persons licensed or permitted by the state to prepare, administer and document the administration of medications may do so .4. Medications are administered in accordance with prescribers orders, including any required time frame .9. The individual administering medication verifies the resident identity before giving the resident his/ her medication .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administering before giving the medication. 11. The following information is checked/ verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. 12. The expiration/ beyond you stay on the medication label is checked prior to administering .</p> <p>Record review of the reference by <a href="https://www.hhs.texas.gov/MedicationAdministrationModule">https://www.hhs.texas.gov/MedicationAdministrationModule</a>, dated May 2017 revealed in part, .Safe medication administration is essential to nursing practice, and nurses need to have knowledge and skill in techniques of administering all pharmaceutical agents because the nurse is the last line of defense to protect a resident against a medication error .Rights of Medication Administration .The number of rights of medication administration can vary significantly depending on the source that is being used .Right Drug .Right Dose .Right Route .Right Time .Right Resident .Right Documentation .A medication error is defined as the preparation or administration of medications or biologicals which is not in accordance with .Accepted professional standards and principles which apply to professionals providing services . Accepted professional standards and principles include the practice regulations in the state of Texas and current commonly accepted health standards established by national organizations, boards, and councils .</p> <p>Record review of the Texas Administrative Code, Title 25, Part 1, Chapter 117, Subchapter D, revealed in part, .All medications shall be administered by the individual who prepared the medication .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39075</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 2 of 8 medication carts and 2 of 21 Residents (Resident #72 and #84) reviewed for labeling and medication storage:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the medication cart used on the 200-unit had pharmacy labels on 7 out of 11 insulin pens in the cart, medications were not left on the medication cart counter, and the medication cart was locked.</li> <li>2. The facility failed to ensure the medication cart used on the 400-unit was locked and medications were not left on the medication cart counter.</li> <li>3. The facility failed to ensure Resident #72 did not have medicated mentholated ointment (combination product that is used to relieve itching, minor muscle, or joint pain. This product may also be used as a chest rub to soothe symptoms associated with the common cold.) at his bedside.</li> <li>4. The facility failed to ensure Resident #84 did not have a bottle of cough syrup at the bedside.</li> </ol> <p>These deficient practices could affect residents prescribed medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. a. During an observation and interview 2/26/25 at 7:33 a.m. revealed the 200-unit medication cart assigned to LVN A contained 7 out of 11 insulin pens without a pharmacy label. LVN A stated, the insulin pens were delivered from the pharmacy in a multi-count box and the box had the pharmacy label attached to it. LVN A stated, when an insulin pen was removed from the box, it did not have a pharmacy label on it. LVN A stated, nursing would write the resident's name on the insulin cap with a marker, and it was a way to identify which insulin pen belonged to which resident. LVN A stated, the pens don't have a pharmacy label, so we have to write the resident's name on the cap.</li> <li>b. During an observation on 2/26/25 at 7:57 a.m., MA D left the 200-unit medication cart assigned to her unlocked with the keys still on the lock, and a box with a vial of eye drops, and a medication cup with crushed medications mixed in pudding on top of the medication cart unattended while she washed her hands in room [ROOM NUMBER].</li> </ol> <p>During an interview on 2/26/25 at 8:21 a.m., MA D stated she forgot to lock the medication cart and forgot she had left the medications on top of the medication cart counter. MA D stated, she was not supposed to do that because anybody could take it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an observation on 2/27/25 at 6:26 p.m., MA U left the 400-unit medication cart assigned to her unlocked and left a bottle of medication on top of the medication cart counter unattended when she entered room [ROOM NUMBER].</p> <p>During an interview on 2/27/25 at 6:37 p.m., MA U stated the medication cart should not have been left unlocked because it was a safety hazard and if a patient came up to the cart they could go in the cart and take the medications or the wrong medication. MA U stated, if a resident took the wrong medication, they could have an allergic reaction and get sick.</p> <p>During an interview on 2/27/25 at 5:18 p.m., the DON stated, the facility received some insulin pens in a multi-count box and the box itself had a pharmacy label, but when the box was opened the insulin pens did not have a label. The DON further stated, when nursing obtained an insulin pen from the box, they would write the resident's name on the cap and the date the insulin pen was opened because it was only good for 28 days. The DON stated, a pharmacy label on the pen could be beneficial in a way that it would have all of the information that verified the right person, right dose, right time. The DON stated, it's a safe practice.</p> <p>3. Record review of Resident #72's CCD, dated 2/28/25, and revealed a [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of vomiting, mild cognitive impairment, and age-related cognitive decline.</p> <p>Record review of Resident #72's quarterly MDS assessment, dated 12/16/24, revealed Resident #70's had mild cognitive impairment for daily decision making.</p> <p>Record review of the Resident #72's Care Plan, dated 2/28/25, revealed Resident has experienced a decline in functional independence and requires assistance for ADL and mobility tasks. Potential for improved functional independence with skilled PT and OT interventions. Resident requires partial assistance for personal hygiene tasks.</p> <p>During an observation and interview on 2/27/25 at 10:53 a.m. Resident #72 at a container of medicated mentholated ointment on his dresser. Resident #72 stated he would rub the ointment on his ears by himself.</p> <p>During an interview on 2/27/25 at 10:55 a.m. LVN H stated none of the Resident on the 400 hallway which included Residents #47, #70, and #72 could self-administer medications.</p> <p>4. Record review of Resident #84's face sheet dated 2/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cough, mild cognitive impairment, wheezing and pain.</p> <p>Record review of Resident #84's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.</p> <p>Record review of Resident #84's Continuity of Care Document dated 2/28/25 revealed the resident did not have a current order for scheduled or prn cough syrup.</p> <p>Record review of Resident #84's comprehensive care plan with revision date 2/3/25 revealed the resident had impaired cognitive functioning with impaired safety awareness and judgement.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 2/25/25 at 9:48 a.m., Resident #84 stated all his medications were provided by the facility nursing staff. Resident #84 was observed with a bottle of cough syrup on the nightstand and stated he personally bought the cough syrup, and it was used for nighttime cold and flu and took a dose two days ago. Resident #84 stated, I went to the store and got it, because I had a bad cough.</p> <p>During an interview on 2/27/25 at 4:45 p.m., the DON stated Resident #84 should not have any medication at the bedside and the resident goes out and probably bought it. The DON stated Resident #84 had not been assessed to self-administer medication and taking a medication that was not prescribed could result in the cough syrup interacting with prescribed medications in a negative way. The DON further stated the Administrator had adopted a program where management department heads were assigned to rooms in the halls who made rounds and should have been looking and reported things like medications left at the bedside immediately to nursing.</p> <p>During an interview on 2/27/25 at 5:00 p.m. the Administrator stated she had a meeting with staff to assign certain staff to monitor resident rooms daily. The Administrator stated they should be looking for items they are not allowed to have such as medication, but they cannot go into resident drawers. The Administrator stated when they see prohibited items, they taken them or call family to help if possible.</p> <p>During a follow-up interview on 2/27/25 at 7:40 p.m., the DON stated, the staff cannot leave the medication carts unlocked and unattended or leave medications unattended because other residents could take them.</p> <p>Record review of the facility policy and procedure titled, Storage of Medications with revision date April 2019 revealed in part, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls .Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers .Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing .Unlocked medication carts are not left unattended .</p> <p>Record review of the facility's policy titled Self-Administration of Medications, revised 12/16, stated Resident have the right to self-administer medications if they interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. comprehension of the purpose and proper dosage and administration time for his or her medications; c. ability to remove medication from a container and to ingest and swallow (or otherwise administer) the medication; and d. ability to recognize risk and major adverse consequences of his or her medications .9. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party .</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>45857</p> <p>Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies, and skills set to carry out the functions of the food and nutrition service for 6 (DA K, DA L, DA M, DA N, DW P, and DA O ) of 10 dietary staff reviewed for qualified dietary staff, in that:</p> <p>The facility failed to ensure the DA K, DA L, DA M, DA N, DW P, and DA O had their Texas Food Handler Certificate.</p> <p>This failure could place residents who ate food from the facility's kitchen at risk of not having their nutritional needs met and place them at risk for food born illnesses.</p> <p>Findings included:</p> <p>Record review of four (4) certificates with completion dates ranging from 6/8/23 to 2/24/25. Certificates were titled Texas Food Handler Certification and indicated, renewal due 2 years from completion date. It was noted that certificates for DA K, DA L, DA M, DA N, DW P, and DA O were not found in this stack of certificates.</p> <p>During an interview on 2/26/25 at 5:35 p.m. the DS stated DA K, DA L, DA M, DA N, DW P, and DA O just washed dishes and he did not think they need a food handler certificate.</p> <p>Record review of the facility's policy titled Personnel-General, dated 2021, stated Policy: The food and nutrition services department will be staffed to assure that sufficient, competent, supportive personnel carry out the functions of the department .3. A clearly written job description for each position will be on file and available for staff to review. 4. Food and nutrition services staff will be trained to perform assigned duties and will be expected to participate in inservice programs. The director of food and nutrition services and/or designee will conduct these programs .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45857</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to have hand soap at the handwashing station in the kitchen.</li> <li>2. The facility failed to keep dish racks and juice lines off the floor.</li> <li>3. The facility failed to not store a basket of milk cartons on the walk-in cooler floor.</li> <li>4. The facility failed to date an open package of turkey and 2 open bags shredded cheese.</li> <li>5. The facility failed to date a container of onions, discard a rotten potato, close a bag of grits, and to store an open bottle of sauce in the refrigerator.</li> <li>6. The facility failed to cover Resident #36's lunch tray when placed on the hallway cart.</li> <li>7. The facility failed to ensure the ice machine was clean and there was a cleaning log.</li> </ol> <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During an observation on 2/25/25 at 9:10 a.m. the kitchen handwashing sink had a bag of hand sanitizer in the soap dispenser.</li> </ol> <p>During an interview on 2/25/25 at 9:11 a.m. the DS stated someone must have accidentally put the hand sanitizer in the soap dispenser and he would replace it then because they needed to use hand soap.</p> <ol style="list-style-type: none"> <li>2. During an observation on 2/25/25 at 9:10 a.m. there were two dish rack directly on the kitchen floor.</li> </ol> <p>During an observation and interview on 2/25/25 at 9:10 a.m. DA N was washing dishes. Two empty dish rack were directly on the floor under the dishwashing sink. DA N stated she did not know they could not be on the floor. DA N moved the dish racks onto a crate off the floor after.</p> <p>During an observation and interview on 2/25/25 at 9:27 a.m. there was a box of juice and three lines running from the machine. Two of the lines were resting on the floor. There were several fruit flies flying around the area. The DS stated that he could not see the flies. The DS stated the juice machine was not operating and was not in use.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During an observation and interview on 2/25/25 at 9:12 a.m. crate of milk boxes was on the floor in the walk-in cooler. The DS stated they should not be on the floor and moved them off the floor. There was another box of unknown food on the floor and the DS stated they planned to return it to the supplier because it was bad.</p> <p>4. During an observation and interview on 2/25/25 at 9:16 a.m. there were 2 used undated bags of shredded cheese in the walk-in cooler. A package of turkey was open with no date. The DS stated staff should be dating the food when they receive it and open it.</p> <p>5. During an observation on 2/25/25 at 9:21 a.m. there was a container of onions with no date. There was a container of potatoes one potato was mushy and rotten. On a self was an open bag of grit inside a plastic bag. The plastic bag was open, and the grits were not sealed closed. On the self was a plastic bottle of BBQ sauce that was expanded. The label read to refrigerate after opening. The DS stated the onions should be dated and threw away the rotten potato. The DS stated the sauce was discarded and should have been refrigerated.</p> <p>6. During an observation and interview on 2/25/25 at 12:16 p.m. LVN Q was passing out tray on a hallway. One tray was for Resident #36 did not have a cover on it. LVN Q was asked why it was not covered and stated she was unsure but would return it to the kitchen and get the resident a new tray so the food would be the proper temperature.</p> <p>7. During an observation on 2/25/25 at 9:32 a.m. the ice machine had black spots inside cover above the ice. There was no cleaning log found.</p> <p>During an interview on 2/26/25 at 5:24 p.m. the DS stated the ice machine was last cleaned a few months ago and was not working. The DS stated the ice machine was recently repaired and they began using it. The DS stated there was no cleaning log because it had not needed to be cleaned. The DS stated he could not see the black spots and did not know what they were.</p> <p>Record review of the facility's policy titled Dry Storage Areas, dated 2013, stated dry storage areas will be kept in a condition which protects stored foods from infestation. Procedure: 1. All items must be stored at least 6 inches off the floor. Shelving should be built at least two inches from walls and 18 inches from the ceiling. There must be adequate space on all sides of the stored items to permit ventilation .10. Cleaners with tight fitting would be used for storing they're real, grain products, dried vegetables and broken lots of bulk foods .Care of storeroom .c. Refrigerated and frozen foods are dated upon delivery. Foods with expiration dates are used prior to the date on the package .</p> <p>Record review of the facility's policy titled Ice, dated 2013, stated Ice will be produced and handled in a manner to keep it free from contamination .2. Ice machines will be maintained in a clean and sanitary condition to prevent ice contamination .</p> <p>(continued on next page)</p>		

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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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Hand Washing, dated 2013, stated staff will wash hands as frequently as needed throughout the day following proper hand washing procedures . hand washing facility should be readily accessible and equipped with hot and cold running water, paper towels, so, trash can and signage notifying employees to wash hands. Encourage hand washing instead of the use of chemical sanitizing gel or lotion. If chemical sanitizing gels are used, staff must first wash hands as stated below. Procedure: clean hands and exposed portions of arms immediately before engaging in food preparation including working with exposed food. 1. When to wash hands: after touching bare human body parts other than clean hands and clean, exposed portions of arms. After using the restroom. After caring for or handling service animals or aquatic animals. After coughing, sneezing, or using a handkerchief or disposable tissue, using tobacco, eating or drinking. After handling spoiled equipment or utensils. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing task. When switching from working with raw food and working with ready to eat food. Before donning gloves for working with food. After engaging in other activities that contaminate the hand .</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. (3) At least 15 cm (6 inches) above the floor. (B) FOOD in packages and working containers may be stored less than 15 cm (6 inches) above the floor on case lot handling EQUIPMENT as specified under S 4-204.122.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 2-301.15, Where to Wash. FOOD EMPLOYEES shall clean their hands in a HANDWASHING SINK or APPROVED automatic handwashing facility and may not clean their hands in a sink used for FOOD preparation or WAREWASHING, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 2-301.16, Hand Antiseptics. (A) A hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall: (1) Comply with one of the following: (a) Be an APPROVED drug that is listed in the FDA publication Approved Drug Products with Therapeutic Equivalence Evaluations as an APPROVED drug based on safety and effectiveness; Pf or (b) Have active antimicrobial ingredients that are listed in the FDA monograph for OTC Health-Care Antiseptic Drug Products as an antiseptic handwash, .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 4-204.16, Beverage Tubing, Separation. Beverage tubing and coldplate cooling devices may result in contamination if they are installed in direct contact with stored ice. Beverage tubing installed in contact with ice may result in condensate and drippage contaminating the ice as the condensate moves down the beverage tubing and ends up in the ice. The presence of beverage tubing and/or coldplate cooling devices also presents cleaning problems. It may be difficult to adequately clean the ice bin if they are present. Because of the high moisture environment, mold and algae may form on the surface of the ice bins and any tubing or equipment stored in the bins.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 4-204.17, Ice Units, Separation of Drains. Liquid waste drain lines passing through ice machines and storage bins present a risk of contamination due to potential leakage of the waste lines and the possibility that contaminants will gain access to the ice through condensate migrating along the exterior of the lines. Liquid drain lines passing through the ice bin are, themselves, difficult to clean and create other areas that are difficult to clean where they enter the unit as well as where they abut other surfaces. The potential for mold and algal growth in this area is very likely due to the high moisture environment. Molds and algae that form on the drain lines are difficult to remove and present a risk of contamination to the ice stored in the bin.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&amp;HS, revealed: 3/304.12, In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not time/temperature control for safety food;</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41095</p> <p>Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 2 (Residents #70 and #31) of 3 residents reviewed, in that:</p> <ol style="list-style-type: none"> <li>1. Resident #70's personal refrigerator was observed to have spoiled food and no temperature log.</li> <li>2. Resident #31's personal refrigerator was observed to have expired food and an incomplete temperature log.</li> </ol> <p>This deficient practice could place residents at risk of foodborne illness due to consuming foods which might be spoiled.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During an observation on [DATE] at 9:53 a.m. Resident #70 had a personal refrigerator. There were many containers of lunch meat on a dresser and in the resident's bed. Some of the containers of lunch meat had green spots. On a bedside table were numerous bottles with liquid stains on the outside of them. Resident #70 stated staff did not help him discard of food items in his room or check the refrigerator in his room. Resident #70 did not have a personal refrigerator temperature record log.</li> <li>2. During an observation on [DATE] at 12:37 p.m. Resident #31 had a personal refrigerator. Inside the fridge was a sandwich not in a container appeared to be hard. A open Styrofoam bowl of dried spaghetti and a meatball with green spots on it, several yellow and brown stains on the bottom of the fridge, a juice box that was half stained brown, a white plastic container with an unknown food dated best by [DATE].</li> </ol> <p>Record review of Resident #31's refrigerator temperature record log, dated February 2025, had a recorded temperature and initials on the 17th and 18th. Nothing was recorded in the corrective actions space. The rest of the days were blank.</p> <p>During an interview on [DATE] at 9:58 a.m. CNA G stated sometimes they check the resident refrigerators but sometimes they did not want you (staff) to check them.</p> <p>During an interview on [DATE] at 10:00 a.m. LVN H stated night shift would normally check the resident refrigerators. LVN H stated she had never made sure they were being checked by the night staff. LVN H stated they kept some logs behind the nurse's station. LVN H showed two logs for Resident #81 and Resident #78. LVN H stated they should attempt to help the resident clean out their fridge, so they do not get sick. LVN H stated she would try to get the residents to let her clean their refrigerators.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Personal Food Storage, dated 2013, Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety. Procedure: individuals will be educated on food safe handling and storage techniques by designated facility staff are needed. Staff will examine food for quality (visual, smell, packages close preferences to identify potential concerns. 2. Staff will provide information on safe food storage and handling as deemed appropriate. (For suggestions, see resources: who safety for your left one on the following page) 3. Designated facility staff will be assigned to monitor individual room storage and refrigeration units or beverage disposal, using the tips of the resources: food safety for your loved ones (on following page). 4. All refrigeration units will have the internal thermometer to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperature (see refrigeration and freezer temperature sample forms in this section.)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>45857</p> <p>Based on observation, and interview the facility failed to dispose of garbage and refuse properly for 1 of 2 Dumpsters (Dumpster #1) reviewed for disposal of garbage.</p> <p>The facility failed to ensure Dumpster #1 was closed and trash was not on the ground outside the dumpster and around the facility grounds.</p> <p>These deficient practices could place residents at risk for exposure to germs and diseases carried by vermin and rodents.</p> <p>The findings were:</p> <p>During an observation on 2/25/25 at 11:02 a.m. revealed the side door to dumpster #1 was open.</p> <p>During an observation on 2/26/25 at 5:41 p.m. revealed the side door to dumpster #1 was open. On the ground behind the dumpster was a food wrapper, used gloves, and used masks.</p> <p>During an interview on 2/26/25 at 5:41 p.m. the DS stated the dumpster should not be open but is shared with the whole facility and sometimes others leave it open. The DS stated the trash on the ground and the open dumpster can attract animals and should not be there. The DS stated maintenance was in charge of pick up trash off the facility grounds outside.</p> <p>During an interview on 2/27/25 at 2:44 the MS stated was responsible for picking trash up outside the facility and stated he had picked it up the day before.</p> <p>During an interview on 2/27/25 at 3:13 p.m. the Administrator stated maintenance was responsible for picking up trash outside the facility but any staff could help. The Administrator stated the did an in service the day before about keep the dumpster closed and staff knew to keep it shut. The Administrator stated rodents or animals could be attracted to the open dumpster or trash.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</b></p> <p>Based on observation, interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 of 21 residents (Residents #69 and Resident #74) reviewed for medical records.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #69's physician's orders were updated to include the resident no longer received a puree diet, thickened liquids, and crushed medications.</li> <li>2. The facility failed to ensure Resident #74's physician's orders were updated to include the resident was a DNR status.</li> </ol> <p>These deficient practices could place residents at risk of improper care due to inaccurate medical records.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #69's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dysphagia-oro-pharyngeal phase (difficulty swallowing due to dysfunction in the mouth and throat), and vitamin deficiency.</li> </ol> <p>Record review of Resident #69's most recent annual MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and complained of difficulty or pain with swallowing and received a mechanically altered diet.</p> <p>Record review of Resident #69's Order Summary Report dated [DATE] to [DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- DIET/CONSISTENCY: Mechanical Soft nectar thick liquids with order date [DATE] and no stop date</li> <li>- MEDICATIONS CRUSHED IN PUREE with order date [DATE] and no stop date</li> <li>- THICKENED LIQUIDS: NECTAR with order date [DATE] and no stop date</li> </ul> <p>Record review of Resident #69's Speech Therapy SLP Discharge Summary, dated [DATE] revealed the following:</p> <p>Discharge Recommendations:</p> <ul style="list-style-type: none"> <li>- Solids Diet Recs - Solids = Any/all oral intake</li> <li>- Liquids Diet Recs - Liquids = All Liquids</li> </ul> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Strategies Comp Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquids/solids, rate modification, bolus size modifications and general swallow techniques/precautions upright posture during meals</p> <p>- Supervision - Supervision for Oral intake = Occasional supervision</p> <p>- D/C Recs - Discharge Recommendations: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquids/solids, rate modification, bolus size modifications and general swallow techniques/precautions upright posture during meals</p> <p>- Restorative Programs - Restorative Program Established/Trained = Not indicated at This Time\</p> <p>- Functional Maintenance - Functional Maintenance Program Established/Trained = Not Indicated at This Time</p> <p>Record review of Resident #69's physician's telephone order, dated [DATE] revealed the following orders:</p> <p>- Diet clarification: Regular, thin</p> <p>Record review of Resident #69's physician's telephone order, dated [DATE] revealed the following orders:</p> <p>- 1. DC Skilled ST Services</p> <p>- 2. Medications whole as tolerated.</p> <p>Record review of Resident #69's comprehensive care plan with revision date [DATE] revealed the resident required medications be crushed and mixed into puree textures/consistencies as ordered for the next 90 days and the resident had a potential for dehydration due to mechanically altered diet/liquid textures/consistencies with approaches to provide fresh water at bedside thickened to appropriate consistency in easy reach and in manageable cup.</p> <p>During an interview on [DATE] at 4:05 p.m., the DON stated Resident #69 admitted to the facility already taking medications crushed and pureed meals. The DON stated, approximately three months prior Resident #69 had requested taking his medications whole instead of crushed and he had been evaluated by the SLP and it was determined he was safe to take whole pills. The DON stated, we realize and recognize we have a problem. I won't lie, we still have care plans that have not been updated. The DON further stated, care plans needed to be accurate because it tells you how to care for the patient, and how to provide basic needs. The DON stated, MDS nurses are responsible for updating the care plan, we have had serious issues with care plans. The care plan should be changed as soon as the order is changed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #74's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness, spastic quadriplegic cerebral palsy (a severe condition that affects muscle control and movement in both arms and legs as well as the trunk of the body), and lack of coordination. Further review of Resident #74's face sheet revealed, on the top section of the face sheet was the residents name and DNR in parenthesis next to the resident's name which indicated the resident had a Do Not Resuscitate code status.</p> <p>Record review of Resident #74's most recent quarterly assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.</p> <p>Record review of Resident #74's Physician Order Report dated [DATE] - [DATE] revealed the following:</p> <p>- CODE STATUS: FULL CODE with start date [DATE] and no stop date. Further review of the Physician Order Report revealed on the top section of the report was Resident #74's name and next to the name, DNR in parenthesis.</p> <p>Record review of Resident #74's comprehensive care plan, with revision date [DATE] revealed the resident had a Full Code status and approaches that included to discuss code status and options with the resident at routine intervals and as needed. Further review of the comprehensive care plan revealed, the top of the document had the resident's name and in parenthesis DNR next to the resident's name.</p> <p>During an interview on [DATE] at 9:47 a.m., Resident #74 stated he used to be a full code but after consulting with his family, and because of the severe contractures to the lower extremities, it was best to be a DNR because it would be almost impossible to initiate CPR.</p> <p>During an interview on [DATE] at 11:40 a.m., the DON stated, any physician's orders found on the electronic record reflected all current orders.</p> <p>During an observation and follow up interview on [DATE] at 4:31 p.m., the DON stated, after reviewing Resident #74's Physician Order Report, revealed the resident had DNR orders but the resident was care planned as a full code and had an order for full code. The DON stated, Resident #74 is on hospice, he used to be full code. They go back and forth, the resident and his family, but he is currently DNR.</p> <p>During an interview on [DATE] at 9:44 a.m., the MDS Coordinator stated the care plan was done by a lot of people. The MDS Coordinator further stated she had only been the MDS Coordinator for the past 3 months and she had been working without help for the past month. The MDS Coordinator stated the facility did not have a lot of care plans in place, a lot of them were missing. It is a work in progress. The MDS Coordinator further stated, obviously I had not audited Resident #74's care plan. The MDS Coordinator stated the care plan determined how to guide the staff to take care of the patient.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 5 of 21 residents (Resident #89, Resident #67, Resident #40, Resident #66, and Resident #74) reviewed for infection control:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure LVN A practiced proper hand hygiene when administering medications to Resident #89, Resident #67, and Resident #40.</li> <li>2. The facility failed to ensure LVN J wore a gown during peg tube medication administration for Resident #66 who had orders for EBP and did not contaminate her gloves.</li> <li>3. The facility failed to ensure Resident #74's indwelling urinary catheter bag was not on the floor.</li> </ol> <p>These failures could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. a. Record review of Resident #89's face sheet dated 2/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (chronic condition that affects the way the body processes blood sugar when the body becomes resistant to producing enough insulin to maintain normal blood sugar levels.)</li> <li>b. Record review of Resident #67's face sheet dated 2/28/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes with unspecified complications, and kidney disease.</li> <li>c. Record review of Resident #40's face sheet dated 2/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes with diabetic neuropathy (nerve damage associated with prolonged high blood sugar levels).</li> </ol> <p>(continued on next page)</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 2/26/25 at 7:18 a.m. during the medication pass revealed LVN A at the medication cart preparing an insulin injection for Resident #89. LVN A put on a pair of gloves, did not perform proper hand hygiene, and entered Resident #89's room and administered insulin. LVN A then removed her gloves, did not perform proper hand hygiene, and returned to the medication cart to document in the resident's MAR. LVN A then gathered supplies to obtain an accu check (a brand of blood sugar monitoring device used to measure blood sugar levels obtained from a needle stick usually to the finger) on Resident #67. LVN A then put on a pair of gloves, did not perform proper hand hygiene and obtained a blood sample from Resident #67's 3rd digit on the right hand. LVN A then removed her gloves, did not perform proper hand hygiene and returned to the medication cart to record the results on the resident's MAR. LVN A then obtained Resident #67's insulin pen from the medication cart, put on a pair of gloves, did not perform proper hand hygiene and administered Resident #67 his insulin. LVN A then removed her gloves, did not perform proper hand hygiene and return to the medication cart. LVN A then gathered supplies to obtain an accu check on Resident #40. LVN A put on a pair of gloves, did not perform proper hand hygiene and obtained a blood sample from Resident #40's 2nd digit on the right hand. LVN A then removed her gloves, did not perform proper hand hygiene, and returned to the medication cart and documented in the resident's MAR. LVN A then obtained Resident #40's insulin pen, put on a pair of gloves, did not perform proper hand hygiene, and administered insulin to Resident #40. LVN A then removed her gloves, did not perform proper hand hygiene and returned to the medication cart.</p> <p>During an interview on 2/26/25 at 7:49 a.m., LVN A stated she had forgotten to wash or sanitize her hands between residents and stated it was important because contact between residents could result in an infection. LVN A stated she had received in-service training on infection control practices last Monday and the DON or ADON usually conducted in-service training.</p> <p>2. Record review of Resident #66's CCD, dated 2/28/25, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), gastrostomy status (presence of an artificial opening in the stomach), pressure ulcer of unspecified part of back stage 4, protein calorie malnutrition, anemia (where there are insufficient healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood).</p> <p>Record review of Resident #66's quarterly MDS assessment, dated 12/23/24 revealed his cognition was intact for daily decision making.</p> <p>Record review of Resident #66's care plan, dated 2/27/25, reveled a problem area for RESIDENT IS AT INCREASED RISK FOR MDRO (MULTI DRUG RESISTANT ORGANISM) RELATED TO GTUBE, FOLEY CATH, WOUND 1. Post signs outside of resident room that state the Required precautions and PPE. (should list activities that require gown and gloves.) Check for compliance with infection prevention practices (e.g. hand hygiene and PPE) Ensure the right PPE is available outside of the resident's room .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 2/27/25 between 6:50 p.m. and 7:39 p.m. LVN J administered medication via Resident #66's peg tube. LVN J did not wear a PPE gown during the medication administration. LVN J went to administer cough syrup to resident #66 discovered she need 5 more milliliters. LVN J kept the same gloves on from the medication administration returned to the medication cart opened it, opened the stock bottle of cough syrup poured 5 more mls into the medicine cup, returned the stock cough syrup bottle to the cart, and closed the cart with the gloves still on. LVN J returned to the resident's bedside and continued to administer medications to Resident #66 with the same gloves on.</p> <p>During an interview on 2/27/25 at 7:40 p.m. LVN J stated she was unsure if Resident #66 was supposed to be on EBP. LVN J then went over to a room next door and stated they had moved Resident #66 from a different room and forgot to move the EBP sign. LVN J stated EBP was for immune compromised residents and the gown protects the staff and residents. LVN J stated she should have changed her gloves after she returned to her cart to prevent cross contamination.</p> <p>3. Record review of Resident #74's face sheet dated 2/27/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included urinary tract infection, and spastic quadriplegic cerebral palsy (a severe condition that affects muscle control and movement in both arms and legs as well as the trunk of the body).</p> <p>Record review of Resident #74's most recent quarterly MDS assessment revealed the resident was cognitively intact for daily decision-making skills, required total assistance with bed mobility and transfers and utilized a catheter.</p> <p>Record review of Resident #74's Physician Order Report dated 2/1/25 to 2/28/25 revealed the following:</p> <ul style="list-style-type: none"> <li>- EMPTY FOLEY CATHETER BAG AND RECORD AMOUNT Q SHIFT, every shift; DAY, EVENING, NIGHT, with start date 11/25/24 and no stop date.</li> <li>- PRIVACY BAG IN PLACE ON WHEELCHAIR/BED AT ALL TIMES. FOLEY COLLECTION BAG OFF OF THE FLOOR AT ALL TIMES. Every Shift; DAY, EVENING, NIGHT, with start date 11/25/24 and no stop date.</li> </ul> <p>Record review of Resident #74's comprehensive care plan with revision date 6/18/24 revealed the resident had urinary incontinence with a potential for UTI and approaches that included to check on resident at routine intervals to assess needs and offer assist with toileting tasks.</p> <p>Observation and interview on 2/25/25 at 11:39 a.m. revealed Resident #74 on the bed and the indwelling urinary catheter draining to gravity on the left side of the bed. Resident #74 stated the catheter had only been inserted a week ago and was suggested by hospice services.</p> <p>Observation and interview on 2/27/25 at 2:07 p.m. revealed Resident #74 on the bed and the indwelling urinary catheter bag on the floor on the left side of the bed. CNA R stated the indwelling urinary catheter bag was not supposed to be on the floor because it was a considered a break in infection control.</p> <p>During an interview on 2/27/25 at 2:11 p.m., LVN KK stated, Resident #74's indwelling urinary catheter bag should not be touching the floor because it could cause the resident to develop a UTI and it was considered cross contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/27/25 at 4:31 p.m., the DON stated the indwelling urinary catheter bag should be in a position where the urine is draining to gravity and the bag should be off the floor. The DON further stated, the indwelling urinary catheter bag touching the floor was considered an infection control issue and she expected the resident be safe and be provided with proper care. The DON stated it was the responsibility of the Aides and the Nurses to ensure proper care was given. The DON stated, the resident could develop a bladder infection.</p> <p>Record review of the facility policy titled Infection Control Guidelines for All Nursing Procedures, dated 4/24, stated Purpose To provide guidelines for general infection control while caring for residents .3. Enhanced Barrier Precautions: a. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. b. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. c. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: 1. Wounds or indwelling medical devices, regardless of MDRO colonization status 2. Infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care . 6. Employees must wash their hands for 20 seconds using antimicrobial or non- antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents; b. When hands are visibly dirty or soiled with blood or other body fluids; c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; d. After removing gloves; e. After handling items potentially contaminated with blood, body fluids, or secretions . 7. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations .a. Before and after direct contact with residents .c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications . f. Before moving from a contaminated body site to a clean body site during resident care; g. After contact with a resident's intact skin h. After handling used dressings, contaminated equipment, etc.; i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and j. After removing gloves .</p> <p>Record review of the facility policy and procedure titled, Catheter Care, Urinary with revision date September 2014 revealed in part, .The purpose of this procedure is to prevent catheter-associated urinary tract infections .The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .Be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>45857</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>39075</p> <p>Based on observation, interview, and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 of the facility's laundry department reviewed for patient care equipment in safe operating condition.</p> <p>The facility failed to ensure 1 of 2 washing machines and 1 of 2 dryers were operable.</p> <p>These failures could place residents at risk of needs not being met due to equipment not being operable.</p> <p>The findings included:</p> <p>A record review of the facility's resident roster dated 2/24/25 revealed a census of 84 residents.</p> <p>During the Resident Council meeting conducted on 2/26/25 at 10:08 a.m., residents revealed the facility had only 1 out of 2 washers and 1 out of 2 dryers that were operable and would often break down. Residents also revealed the laundry is often backed up.</p> <p>During an observation and interview on 2/28/25 at 7:53 a.m., the Laundry Assistant Manager stated, the facility had two washing machines and two clothes dryers, but only 1 washer and 1 dryer were operable. The Laundry Assistant Manager stated she had been working for the facility for about a year and the broken units had been inoperable since she started working at the facility. The Laundry Assistant Manager stated the problem had been reported to upper management and was told the units would be replaced. The Laundry Assistant Manager further stated, a repair company had come out to the facility not too long ago and was told the washer was too old and the part may not be available, and the unit should probably be replaced. The Laundry Assistant Manager stated she worked Tuesday through Saturday and the Laundry Aide worked Sunday through Friday. The Laundry Assistant Manager stated it was challenging to keep up with the laundry with one dryer and one washer and a census of over 80 residents.</p> <p>During an interview on 2/28/25 at 8:37 a.m., the Administrator stated she had been employed at the facility since May 2024 and was aware the washer and dryer had not been working since her employment. The Administrator stated the dryer that was still operable broke down a week ago and a vendor came to the facility and repaired it. The Administrator stated, when the dryer went out last week, the staff took multiple loads to the local laundromat in the area. The Administrator stated the vendor informed her the unit needed to be replaced. The Administrator stated the corporate office was made aware and was told to start getting bids for a new unit. The Administrator stated the dryer probably needed to be replaced because it had been out of commission for some time. The Administrator stated the former Maintenance Director was aware of the problem but was unsure if this person had or had not been following up on the problem. The Administrator stated the new Maintenance Director was working on getting the broken units replaced.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/28/25 at 9:28 a.m., the Maintenance Director stated he had only been employed by the facility since January 2025 and was aware the washer and dryer had been inoperable. The Maintenance Director stated he switched to a new vendor for repairs and informed the State Surveyor they were coming out the following day, Saturday 3/1/25, to fix the washer and dryer. The Maintenance Director stated, the one operable dryer went out last week and staff had to go to the local laundromat to dry clothes but only made one trip since the new vendor came to the facility the same day and fixed the broken dryer.</p> <p>Record review of the invoice for repair of the dryer, provided by the Maintenance Director revealed an estimate to repair the unit, dated 11/14/24.</p> <p>Record review of the invoice for repair and maintenance of the washing machine, provided by the Maintenance Director revealed an estimate for repair of the unit, dated 2/24/25.</p> <p>A policy for maintaining essential equipment for resident care was requested on 2/28/25 at 12:39 p.m. and the Administrator stated the facility had no policy.</p>

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</b></p> <p>Based on observations, record reviews, and interviews the facility failed to ensure resident rooms were equipped to assure full visual privacy for each resident for 1 (Resident #66) of 21 rooms reviewed for full visual privacy.</p> <p>The facility failed to provide Resident #66 with a privacy curtain.</p> <p>This failure could cause a decrease in feelings of self-worth by being exposed during cares.</p> <p>Findings included:</p> <p>1. Record review of Resident #66's CCD, dated 2/28/25, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), gastrostomy status (presence of an artificial opening in the stomach), pressure ulcer of unspecified part of back stage 4, protein calorie malnutrition, anemia (where there are insufficient healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood).</p> <p>Record review of Resident #66's quarterly MDS assessment, dated 12/23/24 revealed his cognition was intact for daily decision making.</p> <p>Record review of Resident #66's care plan, dated 2/27/25, reveled a problem area for Resident requires assistance for all ADL and mobility tasks. He is primarily bedbound with very limited tolerance for out of bed activity. Potential for unavoidable decline. Assist resident to turn and reposition Q 2 hours and PRN while in bed and up in W/C. He is dependent for bed mobility and turning and repositioning tasks .</p> <p>During an observation and interview on 2/25/25 at 10:00 a.m. Resident #66 did not have a privacy curtain. Resident #66 was asleep in bed. Resident #66's roommate stated the privacy curtain fell off a long time ago and they never put it back.</p> <p>During an interview on 2/27/25 at 10:55 a.m. LVN H stated she would write down Resident #66 was missing a privacy curtain and let maintenance know.</p> <p>During an interview on 2/27/25 at 2:44 p.m. the MM stated he was made aware a resident was missing a privacy curtain that day but did not know prior to then. The MM stated he needed to order a privacy curtain for the room.</p> <p>During an interview on 2/27/25 at 3:13 p.m. the Administrator stated she saw Resident #66 did not have a privacy curtain, so they spoke to his family member and moved him to a room with a privacy curtain. The Administrator stated they planned to get a privacy curtain installed in the room. The Administrator stated she could not speak to how it would make the resident feel if they did not have a privacy curtain, but the purpose of the privacy curtain was to provide privacy and dignity.</p> <p>(continued on next page)</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Resident Rights, revised 12/16, stated employees shall treat all residents with timely, respect, and dignity. 1. General and state law guaranteed certain basic rights to all residents of this disability through the rights include the residents' rights to .t. Privacy and confidentiality .</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>41095</p> <p>Based on interview and record review, the facility failed to include effective communications as mandatory training for 16 of 16 employees (MDS, CNA S, CNA T, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ and SW) reviewed for training requirements.</p> <p>The facility failed to provided MDS, CNA S, CNA T, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ AND SW with effective communications as mandatory training.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of CNA S's personnel record had a hire date of 06/16/15, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of CNA T's personnel record had a hire date of 02/09/16, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of MA U's personnel record had a hire date of 05/18/20, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of CNA V's personnel record had a hire date of 09/16/19, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of CNA W's personnel record had a hire date of 06/01/21, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of CNA Y's personnel record had a hire date of 11/20/23, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of CNA Z's personnel record had a hire date of 02/17/23, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of the Food Service Supervisors (DS)'s personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>(continued on next page)</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Activity Director's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of RN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of RN II's personnel record had a hire date of 04/02/21, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of MDS's personnel record had a hire date of 12/17/21, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of effective communications as mandatory training.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>41095</p> <p>Based on interview and record review, the facility failed to provide the required education on the rights of the resident and the responsibilities of a facility to properly care for its residents for 09 of 16 employees (CNA W, CNA Y, DS, ACT D, LVN FF, LVN GG, RN HH, LVN JJ, and SW ) reviewed for training, in that:</p> <p>The facility failed to ensure education on the rights of the resident and the responsibilities of a facility to properly care for its residents was provided to CNA W, CNA Y, DS, ACT D, LVN FF, LVN GG, RN HH, LVN JJ, and SW.</p> <p>This failure could affect residents and place them at risk of being uninformed due to lack of staff training.</p> <p>The findings included:</p> <p>Review of CNA W's personnel record had a hire date of 06/01/21, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of CNA Y's personnel record had a hire date of 10/20/23, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of DS's personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of Act D's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of LVN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>(continued on next page)</p>

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  02/28/2025
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.			
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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of education on the rights of the resident and the responsibilities of a facility to properly care for its residents.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>41095</p> <p>Based on interview, and record review, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property, for 7 of 22 staff (DS, ACT D, LVN FF, LVN GG, RN HH, LVN JJ and SW) reviewed for abuse, neglect exploitation training.</p> <p>The facility failed to ensure staff had completed their mandatory abuse annual training.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of DS's personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of Act D's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21 with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of RN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of education on the prevention of abuse, neglect and exploitation of residents.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>41095</p> <p>Based on interview and record review, the facility failed to include training on the QAPI program to outline and inform staff of the elements and goals of the facility QAPI program for 16 of 16 employees (MDS, CNA S, CNA T, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ and SW) reviewed for training requirements.</p> <p>The facility failed to provide MDS, CNA S, CNA T, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ AND SW on the QAPI program as mandatory training.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of CNA S's personnel record had a hire date of 06/16/15, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of CNA T's personnel record had a hire date of 02/09/16, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of MA U's personnel record had a hire date of 05/18/20, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of CNA V's personnel record had a hire date of 09/16/19, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of CNA W's personnel record had a hire date of 06/01/21, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of CNA Y's personnel record had a hire date of 11/20/23, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of CNA Z's personnel record had a hire date of 02/17/23, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of the Food Service Supervisors (DS)'s personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of Activity Director's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>(continued on next page)</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of RN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of RN II's personnel record had a hire date of 04/02/21, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of MDS's personnel record had a hire date of 12/17/21, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of the QAPI program as mandatory training.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>41095</p> <p>Based on interview and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 7 of 16 staff (DS, ACT D, LVN FF, LVN GG, RN HH, LVN JJ, and SW) reviewed for training, in that:</p> <p>The facility failed to ensure infection prevention and control training was provided to DS, ACT D, LVN FF, LVN GG, RN HH, LVN JJ, and SW.</p> <p>This failure could place residents at risk of illness due to lack of staff training.</p> <p>The findings were:</p> <p>Review of DS's personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of Act D's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of LVN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of education on infection control topics.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide training in compliance and ethics.</p> <p>41095</p> <p>Based on interview and record review the facility failed to communicate the compliance and ethics program's standards, policies and procedures through a training program or other practical manner which explains the requirements for 16 of 16 employees (MDS, CNA S, CNA T, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ and SW) reviewed for training requirements.</p> <p>The facility failed to provide MDS, CNA S, CNA T, CNA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ AND SW on the compliance and ethics program's standards, policies and procedures through a training program or other practical manner as required.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of CNA S's personnel record had a hire date of 06/16/15, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of CNA T's personnel record had a hire date of 02/09/16, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of MA U's personnel record had a hire date of 05/18/20, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of CNA V's personnel record had a hire date of 09/16/19, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of CNA W's personnel record had a hire date of 06/01/21, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of CNA Z's personnel record had a hire date of 02/17/23, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of the Food Service Supervisors (DS)'s personnel record had a hire date of 05/22/23, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of Activity Director's personnel record had a hire date of 12/02/24, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>(continued on next page)</p>

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of LVN FF's personnel record had a hire date of 11/19/21, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of RN HH's personnel record had a hire date of 10/01/14, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of RN II's personnel record had a hire date of 04/02/21, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of MDS's personnel record had a hire date of 12/17/21, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>Review of SW's personnel record had a hire date of 06/19/22, with annual training in-services provided by the facility that did not include evidence of the compliance and ethics program's standards, policies and procedures as required.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>41095</p> <p>Based on interview and record review, the facility failed to provide mandatory behavioral health training for 15 of 16 employees (MDS, CNA S, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ and SW) reviewed for training, in that:</p> <p>The facility failed to ensure effective behavioral health training was provided to MDS, CNA S, MA U, CNA V, CNA W, CNA Y, CNA Z, DS, ACT D, LVN FF, LVN GG, RN HH, RN II, LVN JJ and SW.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of MDS's personnel record had a hire date of 12/17/21 revealed no evidence of behavioral health training.</p> <p>Review of CNA S's personnel record had a hire date of 06/16/15 revealed no evidence of behavioral health training.</p> <p>Review of MA U's personnel record had a hire date of 05/18/20, revealed no evidence of behavioral health training.</p> <p>Review of CNA V's personnel record had a hire date of 09/16/19 revealed no evidence of behavioral health training.</p> <p>Review of CNA W's personnel record had a hire date of 06/01/21 revealed no evidence of behavioral health training.</p> <p>Review of CNA Y's personnel record had a hire date of 11/20/23 revealed no evidence of behavioral health training.</p> <p>Review of CNA Z's personnel record had a hire date of 02/17/23 revealed no evidence of behavioral health training.</p> <p>Review of DS's personnel record had a hire date of 05/22/23 revealed no evidence of behavioral health training.</p> <p>Review of Act D's personnel record had a hire date of 12/02/24 revealed no evidence of behavioral health training.</p> <p>Review of LVN FF's personnel record had a hire date of 11/19/21 revealed no evidence of behavioral health training.</p> <p>Review of LVN GG's personnel record had a hire date of 09/16/22 revealed no evidence of behavioral health training.</p> <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of RN HH's personnel record had a hire date of 10/01/14 revealed no evidence of behavioral health training.</p> <p>Review of RN II's personnel record had a hire date of 04/02/21 revealed no evidence of behavioral health training.</p> <p>Review of LVN JJ's personnel record had a hire date of 10/08/18 revealed no evidence of behavioral health training.</p> <p>Review of SW's personnel record had a hire date of 06/19/22 revealed no evidence of behavioral health training.</p> <p>During a record review and interview with the HR Personnel on 02/28/25 at 9:00 am, the HR Personnel revealed she was only responsible for the initial orientation training. All other training was provided by the DON or Administrator.</p> <p>During an interview with the DON on 02/28/25 at 1:00 pm, she stated she does meetings or inservices weekly. The DON stated she does the trainings based on issues that needed to be addressed and there was no set curriculum or guidelines that were followed.</p>