

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/31/2025
NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen. The facility failed to date food and beverages found within the facility's freezer and refrigerator on 12/29/2025. The facility failed to date and properly seal food products in facility freezer and refrigerator on 12/29/2025. These failures could place the residents who ate food from the kitchen at risk of cross contamination, loss of nutritional value, weight loss, and foodborne illness. Findings included: In an observation on 12/29/2025 at 9:15 AM, the facility's one door freezer was found to contain an open undated box of breakfast sausage patties with a partially opened bag of breakfast sausage patties that were exposed to air. The freezer contained a large clear plastic bag with green peas covered with ice. There was no date or label on the bag. The freezer contained 5 individual servings of vanilla ice cream that had leaked into inside of the box and the lids on two of the containers had slid to the side exposing the ice cream to the air. In an observation on 12/29/2025 at 9:22 AM, the facility's single door refrigerator was found to contain a plastic container labeled Golden Italian Dressing. There was no open date or expiration date on the container. In an interview on 12/30/2025 at 10:30 AM, the DM stated that the box containing the individual ice cream should have been thrown out. The DM said the salad dressing container II showed him in the refrigerator should have been dated and labeled. The DM stated that failure to properly seal bags containing food in the freezers could lead to freezer burn. He stated this could cause the residents to get stomachaches or make them sick. In an interview on 12/30/2025 at 2:55PM the Consultant Dietician stated she understood the importance of labeling and dating food when it comes in and when it was opened. She stated residents could become ill if items are not properly dated and labeled. She told me she had in serviced the dietary staff on labeling and dating food that morning. Review of Chapter 3 Food Production and Food Safety Policy and Procedure Manual dated 2023, Policy: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Procedure: 7. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. B. Food should be dated as it is placed on the shelves if required by state regulation. C. Date markings should be visible on all high-risk food to indicate the date by which a ready to eat food should be consumed, sold or discarded. 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. 13. Refrigerated food storage: f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. 14. Frozen Foods. C. All foods should be covered, labeled and dated. All foods will be checked to ensure that foods will be consumed by their use by dates or discarded.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675918	Facility ID: 675918 If continuation sheet Page 1 of 5

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure evidence reflects the facility did not complete a discharge summary to include a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge as resident was discharged to the hospital for a change in condition and the family chose to not readmit to the facility for 1 (Resident #94) of 4 residents reviewed for safe transfer or discharge. The facility failed to record the reasons for the transfer/discharge in Resident # 94's medical record when discharged on 11/30/2025. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings included:Record review of Resident # 94's face sheet dated 12/31/2025 reflected a [AGE] year-old female admitted on [DATE] and discharged on 11/30/2025.Record review of Resident # 94's continuity of care document dated 12/31/2025 reflected diagnosis of infection following a procedure, other surgical site, elevated white blood cell count, muscle weakness, abnormalities of gait and mobility, lack of coordination, type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or can't use the insulin properly, leading to high blood sugar levels because sugar can't get into cells for energy), GERD (a chronic digestive disorder where stomach acid frequently flows back into the esophagus), hyperlipidemia (fat particles in the blood), history of malignant neoplasm of breast (breast cancer), acute postprocedural pain, lymphedema (swelling caused by buildup of protein-rich lymph fluid in soft tissues because the lymphatic system is damaged or blocked preventing proper fluid drainage), and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (the deepest layer of the skin).Record review of Resident # 94's baseline care plan reflected a completion date of 11/202/2025 with needs of assist by 1 for bed mobility, bathing, and grooming/hygiene. Assist by 2 for locomotion and transfers. Total dependence on walking and toileting. Set up assist for eating. Further review reflected Resident # 94 had a wound vac required a specialty mattress and required turning and repositioning.Record review of Resident # 94's comprehensive MDS dated [DATE] reflected a BIMS score of 14 indicating intact cognition. Further review of section GG functional abilities reflected substantial/maximal assistance required for toileting hygiene, shower/bathing, upper body dressing, and putting on footwear. Resident # 94 was dependent on staff for lower body dressing. Resident # 94 required partial/moderate assistance for transfers and personal hygiene.In an interview on 12/31/2025 at 12:30 pm with RNC revealed RNC stated for resident discharges there should be a progress notification regarding discharge or hospitalization to the RP, ADM, and MD. RNC stated after the resident went out to the hospital and did not return the SW should have put in a progress note about the resident discharge. RNC stated she had called the LVN that completed the hospital discharge and the LVN told her that the family was present when the JP drain was dislodged and was made aware that the resident would have to go to the hospital to have the JP drain reinserted. RNC stated it was her expectation that a progress note be documented in the resident chart to show that the RP was notified of the resident transfer. RNC also stated it was her expectation that when a resident is discharged that a progress note be put in the EHR for the resident regarding the resident discharge and the notifications made. RNC stated it could negatively impact resident care if documentation is not completed.Attempted telephone interview with LVN A on 12/31/2025 at 3:33 pm no answer voicemail left awaiting return call.In an interview on 12/31/2025 at 4:03 pm with LVN B revealed LVN B has worked at the facility for 26 years. LVN B stated she has received many ANE and Resident Rights trainings. LVN B stated for the discharge or hospitalization process that there are many steps. LVN B stated the first step for a COC is the required parties are notified including the DON, NP, RP, and ADM then the COC order is written. LVN B stated a progress note is documented in the resident EHR and it is also documented in the COC binder and the 24-hour (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report. LVN B stated all COC, and discharges are also discussed when the verbal shift change report is conducted. LVN B stated she was unsure if it could negatively affect a resident if the party notification is not documented but she knew it would disrupt the communication chain for the staff and could potentially cause issues if staff were unaware of resident status or where a resident was. In an interview on 12/31/2025 at 4:20 pm with DON revealed DON stated it is was her expectation that for COC's and discharge that the required parties are notified and that the notification is documented in the EHR. The nurse that sends the resident out or whoever assisted in the process is responsible for documenting for the resident. DON stated she did not feel it could negatively affect the resident or staff by not documenting the required notifications because all the information had been communicated verbally there was just not a progress note charted. In an interview on 12/31/2025 at 4:41 pm with the ADM revealed ADM stated it was her expectation that a progress note would have been put in the EHR stating that the family was present and notified upon the resident's discharge for her COC. ADM stated the charge nurse is was responsible for completing the documentation relating to the discharge of the resident. ADM stated she did not feel it could negatively affect the residents' care for not putting a progress note in concerning her discharge since she was in the hospital. Record review of nursing progress note by LVN A dated 11/30/25 1:45 pm reflected Jackson Pratt tube pulled out reported by wound nurse. EMS called and will be here anytime to pick Resident # 94 up to transport to hospital for reinstalment. Record review of nursing progress note by LVN C dated 11/30/2025 6:57 pm reflected Resident # 94 remains at hospital. Record review of nursing progress note ADM dated 12/1/2025 recorded as a late entry created on 12/31/2025 reflected ADM and Admissions Director went to visit Resident 94 at the hospital. The resident was unavailable after 2 attempts to visit due to receiving wound care. Admissions Director to follow up with family. Record review of nursing progress note by ADM dated 12/15/2025 recorded as late entry created on 12/31/2025 reflected ADM notified the Regional Business Development and the BOM that the family was choosing to have their loved one go to an alternative facility. ADM stated the family had concerns related to wanting their loved one to be in a higher level of care. Record review of facility Change in a Resident's Condition or Status policy dated 05/2017 reflected under policy statement: Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. Under policy interpretation and implementation: 8. The nurse will record information on the resident's medical record information relative to changes in the resident's medical/mental conditions or status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to develop and implement an accurate comprehensive person-centered care plan that met the residents' medical needs and treatment plan for 1(Resident # 38) of 6 residents reviewed for comprehensive care plans. The facility failed to provide interventions / approaches consistent with facility policy of being a non-smoking facility for Resident # 38 vape use listed as a problem on her care plan. This failure could affect residents by placing them at risk of not receiving appropriate interventions and care to meet their current needs. Findings included: Record review of Resident # 38 face sheet dated 12/31/2025 reflected a [AGE] year-old female admitted on [DATE]. Record review of Resident # 38 continuity of care document dated 12/31/2025 reflected a diagnosis of unspecified visual loss, cough, pain, age related cataract bilateral (a clouding of the eye's natural lens causing blurry or hazy or dim vision on both eyes), depression, muscle weakness, lack of coordination, unspecified asthma, chronic obstructive pulmonary disease (a progressive group of lung disease that block airflow and make breathing difficult), hear failure, cardiomyopathy (a group of diseases affecting the heart muscle making it difficult for the heart to pump blood effectively to the body), hyperlipidemia (fat particles in the blood), hypertensive heart disease with heart failure (heart problems caused by long term high blood pressure where the heart muscle thickens and has to work harder to pump blood), and tremors. Record review of Resident # 38's quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating intact cognition. Further review reflected under section GG functional abilities resident required set up or clean up assist for eating, toileting, dressing, and personal hygiene. Resident # 38 required supervision or touching assist for shower/bath and shower/bathing transfer. Resident # 38 was independent for transfers. Record review of Resident # 38's comprehensive care plan dated 12/17/2025 reflected a problem of resident uses vape dated 5/19/2025 with intervention and approaches of explain/show where designated smoking areas are repeat PRN. Post smoking schedule for resident to refer to facility smoking times. Staff to supervise during use of vape as needed. In an interview on 12/31/2025 at 3:50 pm with MDS Nurse D revealed MDS Nurse D stated she was unaware that Resident # 38's care plan had approaches concerning her vape use that were inconsistent with facility policy. MDS Nurse D stated she and her fellow MDS Nurse E were responsible for completing the care plans. MDS Nurse D stated that she did not believe it could negatively impact the residents care if her care plan was not correct concerning the resident vaping since the resident was alert and oriented x4 and goes outside to vape after signing herself out since the facility is non-smoking. In an interview on 12/31/2025 at 4:20 pm with DON revealed DON stated it depends on the specific information being documented in the care plan as to whether it could negatively affect the resident. DON stated MDS is responsible for updating care plans. DON stated she has received ANE and Resident Rights training and has worked at the facility for 2 years. DON stated it was her expectation that each care plan would be tailored for the individual resident and that there is consistency with facility policies and procedures. In an interview on 12/31/2025 at 4:41 pm with ADM revealed ADM stated the MDS nurse complete the comprehensive part of the care plan and the charge nurse completes the acute care part of the care plan. ADM stated it was her expectation that care plan approaches coincide with facility policy and procedure. ADM stated that depending on what the information in question is could potentially negatively impact a resident but thankfully in this instance it did not. It had the potential to affect them emotionally and possibly cause frustration. ADM stated the MDS Nurse E who had completed the care plan for Resident # 38 had previously worked at a smoking facility and she felt that is where she drew her knowledge base from. ADM stated she would be educating the MDS Nurse E and explaining this facility policy and procedures. Record review of facility Care plans, Comprehensive person-centered policy dated 12/2026 reflected under policy (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement:A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.Under policy interpretation and implementation:8. The comprehensive person-centered care plan will:g. incorporate identified problem areash. incorporate risk factors associated with identified problemsk. reflect treatment goals, timetables and objectives in measurable outcomesl. identify the professional services that are responsible for each element of care10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are the endpoint of an interdisciplinary process.11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.Record review of facility Smoking policy undated reflected the facility was a smoke-free and tobacco-free facility. Smoking is strictly prohibited on campus for all residents. Residents who wish to smoke may do so only after signing out and leaving the facility grounds. Lighters and smoking paraphernalia are not permitted within the facility. Residents may request that a nurse secure such items until they are ready to leave the premises. Any smoking related items found on-site will be confiscated and securely stored by nursing staff until the resident signs out. This facility does not oversee or manage resident smoking.		