STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675918	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents for 3 of 12 residents (Residents #8, 19 and 25) reviewed for dignity and use of personal possessions.The facility failed to ensure NA K treated Resident #19 and Resident #8 with dignity when he tried to provide Resident #19 redirection and walked into Resident #8's room while speaking into a Bluetooth earpiece.The facility failed not to clutter Reisdent#25's space in her room with facility owned oxygen concentrator, oxygen cylinder and laundry basket of her roommate.These failures placed residents at risk of an escalation of behaviors in dementia and discomfort, accidents and a diminished quality of life. Findings included:1. Review of the undated face sheet for Resident #19 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease and mood disorder due to known physiological condition. Review of the quarterly MDS for Resident #19 dated 02/26/2026 reflected a BIMS score of 11, indicating a moderate cognitive impairment. Review of the care plan for Resident #19 dated 05/25/2026 reflected the following: PROBLEMImpaired social interaction related to cognitive impairment, anxiety, or unmet needs as evidenced by intrusive behaviors such as entering others' rooms, pushing residents in their wheelchair, or invading personal space.GOALResident will maintain appropriate boundaries with minimal staff cueing thru the next 90 days.APPROACHRedirect resident calmly when approaching others' rooms or personal space. Offer meaningful activities. Provide structured routines. Use consistent boundary-setting phrases (?This is [another resident's] room; let's go this wayinstead.')Use simple, clear instructions and calm tone. Provide reassurance if resident appears anxious or fearful. Review of the undated face sheet for Resident #8 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body), cognitive communication deficit (problems communicating due to cognitive impairment), mood disorder, anxiety disorder, and need for assistance with personal care. Review of the quarterly MDS for Resident #8 dated 02/26/2026 reflected a BIMS score of 12, indicating a moderate cognitive impairment. Review of the care plan for Resident #8 dated 03/03/2026 reflected the following: PROBLEMResident has impaired cognitive functioning S/P CVA (after a stroke) with residual Cognitive Communication deficit. She is forgetful, is impulsive and has impaired problem solving, safety awareness, memory.GOALResident will be assisted with memory, decision making/ safety, orientation with dignity X 90 days.APPROACH-Check on resident at routine intervals to assess needs and monitor safety issues. Provide needed care PRN.-Explain each activity/care procedure prior to beginning.-Orient to surroundings, staff, environment, ADL needs and activities. Observation on 06/03/2026 at 2:12 PM revealed NA K was standing on the hall where Resident #19 and Resident #8 lived. He had a Bluetooth earpiece in his left ear and was talking very quietly and very quickly. Resident #19 came out of her room with a handful of paper towels. As she approached NA K with the paper towels, he was talking almost constantly, apparently into his (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bluetooth earpiece. He took the paper towels from her and disposed of them. He then said to her Come on (Resident #19) let's go to your room and was still speaking into the earpiece before and after speaking to her. She pursed her brow and looked at him with an angry expression. He shrugged and walked the other direction, still speaking intermittently into his earpiece. Another staff person came up to Resident #19 and directed her to an activity. NA K then walked down the hall and into Resident #8's room, where he stood just inside the doorway talking quietly for 30 seconds. Resident #8 did not respond to his presence in her room. During 06/04/2026 at 1:28 PM, LVN C stated she had worked with NA K a little bit but not very much. She stated she taught the student nurse aides and educated the CNAs when there was some change they needed to know about on the hall. She stated she has tried to explain to the staff who did not speak English that they should not just nod their heads and agree but to make sure they understand what is being communicated. She stated educating the staff on things might have required more than one time of explaining to him. She stated she was not sure if NA K knew the best way to redirect Resident #19. She stated he should have known staff were not allowed to be on their phones or Bluetooth. She stated the student nurse aides should have been shadowing CNAs and learning the job, not just standing around on the phone. She stated the potential negative impact on residents of staff trying to provide care while on the phone was the staff would not be able to pay attention to what the resident needed. During an interview using a telephone interpreter on 06/04/2026 at 2:47 PM, NA K stated he had worked at the facility for one month. He stated he had training on redirecting residents with dementia. He stated he was still in training. He stated if a resident was angry or upset he had to report to the nurse or authority. He stated it was not acceptable to use the phone while working. He stated he only used his phone while in the breakroom. He stated the Bluetooth earpiece he had on the day before was for English lessons he was listening to. He stated when he was talking, he was practicing English. He stated he did not walk into Resident #8's room to engage her, but he was just checking on her. He stated he did not mean to have his earpiece on while he was redirecting Resident #19 or going into Resident #8's room. He stated he wanted to apologize, as he did not mean to be disrespectful to the residents, but he was still learning. During an interview on 06/04/2026 at 3:31 PM, the DON stated she was responsible for training staff to be respectful to residents and treat them with dignity. She stated she ensured staff were trained in a language they understood by checking for understanding and providing online translation for more complicated instruction. She stated she in-serviced about cell phone use and did not allow it on the hall at all. She stated the no cell phones policy applied to Bluetooth earpieces or headphones, as well. She stated they should not have been worn or listened to by any staff on the hall. She stated a potential negative impact on residents was they would feel like they were not listened to. During an interview on 06/04/2026 at 4:00 PM, the ADM stated she had in-serviced the staff several times about cell phones, earpieces, and headphones being prohibited while on duty. She stated that use of cell phones, earpieces, or headphones was not allowed anywhere except the employee break room. She stated she expected staff would not be on their phones while working. She stated the rule was in the employee handbook. She stated she ensured staff who did not speak English learned the material by making the teaching tool they used for abuse/neglect/exploitation training available in nine languages. She stated all their in-services were presented in English, Spanish, and French. She stated the potential negative impact of the staff being on cell phones while caring for residents was a lack of attention and not being heard. 2. Review of Resident #25's face sheet dated 06/02/26 reflected Resident #25 was initially admitted to the facility on [DATE] and readmitted on [DATE]. She was a [AGE] year-old female diagnosed with seizures, cerebral palsy, legal blindness, need for assistance with personal care, muscle weakness , lack of coordination, drug induced secondary parkinsonism(shaking) and muscle spasm (muscle cramp). Review of Resident #25's initial MDS dated [DATE] reflected a BIMS score of 12 indicating her cognition was moderately impaired. Review of Resident #25's care plan dated 04/02/26 reflected that :Resident #25 preferred her bed to be placed against the wall, and the relevant intervention was ensuring adequate access to call bell, light, and (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal items on the open side.Resident #25 had severely impaired vision and was legally blind. The relevant intervention was not to rearrange furnishings to enable the resident to recognize objects/own environment.Resident #25 was potential for falls due to history of falling. The relevant intervention was to keep the floor clean and dry and clutter free environment.During an observation and interview with the FM of Resident #25 on 06/02/26 at 11:20 a.m., it was revealed that Resident #25 was sharing the room with another resident who was in hospice care. There was an oxygen cylinder, an oxygen concentrator, and a laundry basket stored in the area designated for Resident #25. The FM stated that these items belonged to Resident #25's roommate. She said that the staff had stored these items in Resident #25's space, likely for convenience. She said ,although she was okay with the arrangement since the roommate was in hospice care, she expressed dissatisfaction because this setup restricted the room space allocated for Resident #25. During an interview on 06/04/26 at 12:35 p.m., LVN B, the nurse in charge of Hall 500 where Resident #25 resides, stated that the oxygen cylinder, concentrator, and laundry basket in Resident #25's room were for Reisdent#25's roommate for using in emergency situations. LVN B explained that organizing these items within the room was necessary to ensure they were readily available, given that Resident #25's roommate was in hospice care. She said that the equipment was the property of the facility and should have been placed in the designated area for Resident #25's roommate. LVN B stated that the setup in Resident #25's area was done solely by the facility staff and that there was no pressure from Resident #25's roommate or her family for storing them in Resident #25's space. She stated that this situation was a violation of Resident #25's right to have her permitted space, as the items belonging to her roommate cluttered the area. LVN B stated that the staff had not taken steps to remove the items because neither Resident #25 nor her family had made any complaints or observed of having any inconvenience due to them. During an interview on 06/04/26 at 4:10 p.m., the DON stated that it was the right of each residents to have their allotted space in their room available for their personal needs. She said that storing items that did not belong to Resident #25 diminished the usable space designated for her. The DON said that she was not aware of this situation, as neither Resident #25 nor staff had brought it to her attention. She stated she would make alternative arrangements to store her roommate's equipment elsewhere safely to ensure Resident #25 can fully utilize her space. Review of the facility policy Resident Rights revised in December 2016 reflected: Employees shall treat all residents with kindness, respect and dignity.Federal and state laws guarantee certain basic rights to all residents of this facility . These rights include the residents' right to:a dignified existence;be treated with respect, kindness, and dignity;Exercise his or her rights without interference, coercion, discrimination or reprisal from the facility;ae. Retain and use personal possessions to the maximum extent that space and safety permits.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who is unable to carry out activities of daily living, receives the necessary services to maintain grooming and personal care for 3 of 8 residents (Resident #45 and Resident #88 and Resident #67) reviewed for ADL care. The facility failed to provide nail care to Resident #45 and Resident #88 and Resident #67, leaving the nails on the fingers and toes , long, and discolored. This failure could place residents at risk of social embarrassment, isolation, infection, injury, pain, deterioration of health and a diminished quality of life. Findings included:Resident #88Record review of Resident #88's face sheet dated 06/02/26 reflected Resident #88 was admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with cerebral infarction (stroke), lack of coordination, muscle weakness, muscle spasm, anemia and contracture of the hand (tightening of the hand muscles).Record review of Resident #88's quarterly MDS dated [DATE] reflected that an assessment for BIMS could not be completed as the resident was rarely/never understood. Further review revealed that for self-care he was fully dependent.Record review of Resident #88's care plan dated 04/22/26 reflected that he required assistance for performing ADLs and mobility tasks due to the history of CVA(stroke). He had reduced ROM to bilateral elbows, wrists, hands and left lower extremity weakness. The relevant intervention was to provide moderate assistance for personal hygiene tasks.An observation on 06/02/26 at 09:47am, revealed Resident #88 was in bed . He had contracted hands, with nails about 1/2 inch long on both the hands. The nails were thick and yellow. Resident #88 nodded yes when asked if he wanted his nails to be trimmed.Resident #45Record review of Resident #45's face sheet dated 06/02/26 reflected Resident #45 was admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with Parkinsonism(a group of neurological disorders that cause movement problems, such as tremors, slow movement, stiffness, and balance issues), Other lack of coordination, Weakness, Localized edema, chronic pain, Wrist drop and left wrist and Muscle weakness.Record review of Resident #45's initial MDS dated [DATE] reflected a BIMS score of 07 indicating his cognition was severely impaired. Further review revealed he was fully dependent for self-care.Record review of Resident #45's care plan dated 05/14/26 reflected that he had a significant decline in functional independence for ADL and mobility tasks due to generalized weakness, poor endurance / activity tolerance, impaired balance and Parkinson's Disease with Tremor. The relevant intervention was providing Resident #45 moderate assistance for personal hygiene tasks.An observation on 06/02/26 at 10:30am revealed Resident #45 was in bed . Both of his hands had tremors. All the nails on both the hands were about 1/2 inch long and were thick and yellow. Resident #45 stated he wanted his nails to be trimmed and said he did not remember whether he was offered nail trimming or when they were trimmed lately.Resident #67Record review of Resident #67's face sheet dated 06/03/26 reflected Resident #67 was initially admitted on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male diagnosed with acute respiratory failure with hypoxia (low oxygen), congestive heart failure, Type 2 diabetes mellitus, muscle weakness, muscle wasting, and lack of coordination.Record review of Resident #67's initial MDS dated [DATE] reflected a BIMS of 14 indicating his cognition was intact. Further review indicated that he was independent with personal hygiene. Record review of Resident #67's care plan dated 03/09/26 reflected resident was primarily independent for ADL and mobility tasks however had potential for decline in functional independence due to Spinal Stenosis (narrowing of the spaces within your spine), Neuropathy (nerve damage) and history of pain. Relevant intervention was encouraging /reminding resident to use bell to call for assistance and checking on resident at routine intervals to assess needs, monitoring safety issues and offering assistance as needed.During an observation and interview on 06/03/26 at 2:30pm , Resident #67 stated he was able to trim his fingernails independently however was unable to bend down and trim his toenails. Observation of his feet (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed that the toenails were about 1/2 inch long on both the feet. He stated that he neither requested nor had any staff offered trimming toenails. Resident #67 stated staff did a skin assessment recently and might have noticed the overgrown toe nails. During an interview conducted on 06/04/26 at 2:35 PM, CNA H stated that she began working at the facility about a month ago and had worked in all halls, including Hall 500. She said that she did not notice any residents with overgrown nails in Hall 500. CNA H stated that if she were to find any residents with overgrown nails, she would report it to the nurse in charge rather than trimming them herself, as in some disease conditions might not be safe to handle without clinical expertise. She added however, that she would clean the nails if they were dirty and then report the issue to the nurse.During an interview conducted on 06/04/26 at 2:50 pm, CNA G stated that he had been working at the facility for three months and had noticed overgrown nails on Residents #45 and #88 about a week ago. He stated that he was unaware of the toenails of Resident #67 . CNA G said that he informed the charge nurse at that time about the overgrown nails; the charge nurse was a different individual than LVN B. He stated he would trim the nails if the nurse assessed the resident and determined it was safe to do so. CNA G said it was not safe to trim complex nail growth or nails of residents with conditions such as diabetes unless performed by someone properly trained. CNA G also stated that trimming nails in a timely manner was important to prevent the spread of infectious diseases transmitted through debris accumulated in the nail beds.During an interview on 06/04/26 at 12:35 PM, LVN B stated that she was the nurse in charge of Hall 500, where Resident #45, Resident #88, and Resident #67 reside. LVN B said she had offered to clip Resident #45's nails approximately one week ago; however, he declined the offer. She said that she would encourage him again to have his nails trimmed. LVN B stated she did not know why the nails of Resident #88 had not been trimmed. She also said, Resident #67 was capable of trimming his own nails and was unaware of the long toenails of Resident #67. LVN B stated she preferred a podiatrist to perform this task, considering that Resident #67 was diabetic and required the expertise of a podiatrist. She stated that regular nail trimming was important for the residents to prevent injuries and infections.During an interview on 06/04/26 at 4:10 PM, the DON stated that there was no reason for Resident #45, Resident #88, and Resident #67's nails not to have been cut. She explained that at the facility, nurses were responsible for nail trimming, and CNAs were tasked with informing the nurse in charge of any residents with overgrown fingernails. She further stated that if a resident declines the service, the nurse should approach the resident two more times. If the resident still refuses, the nurse must report this to the DON, and the IDT would intervene. The DON stated that the facility maintains a file for documenting nail trimmings, and the ADON routinely audits this file. The DON said she would be investigating why the nails of Residents #45, #88, and #67 were not trimmed in a timely manner. She said that overgrown nails were an infection control concern, as the nail bed can harbor germs that cause infectious diseases. Additionally, she noted that long nails can cause scratches and injuries, which could have more serious consequences for residents with diabetes, peripheral vascular disease, or those taking blood thinners.Record review of the facility policy Fingernails/Toenails, care of revised in February 2018 reflected : Purpose: The purposes of this procedure are to clean the nailbed, to keep nails trimmed and to prevent infections.General Guidelines:Nail care included daily cleaning and regular trimming.Proper nail care can aid in the prevention of skin problems around nail bed.Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments.Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.Reporting:1.Notify the supervisor if the resident refuses the care.2. Report on other information in accordance with the facility policy and professional standard of practice.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 1ˆresident (Resident #38) reviewed for privacy. The facility failed to ensure CNA D and CNA E provided privacyˆby drawing the privacy curtain during incontinent careˆfor Resident #38. ˆThis failure could place residents at risk of feeling embarrassed, diminishing the residents' quality of life and not having residents' rights acknowledged.Findings Included: Record review of Resident #38's undated face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Heart failure, unspecified (heart cannot pump enough blood to meet the body's needs, but the exact type such as systolic or diastolic is not yet determined), obstructive and reflux uropathy, unspecified (urinary tract blockage or urine flowing backward into the kidneys. The root cause is not currently specified), Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (dementia symptoms such as memory loss and cognitive decline but a doctor cannot definitively determine the exact underlying cause without exhibiting behavioral, psychotic, mood, or anxiety disturbances), age-related physical debility (geriatric syndrome characterized by a loss of muscle mass, decreased physiological reserve, and increased vulnerability to stressors). Record review of Resident #38's Comprehensive MDS Assessment, dated 03/05/2026, reflected Resident #38ˆhad a BIMS score of 07 indicating severe cognitive impairment.ˆResident #38 had indwelling catheter, including suprapubic catheter and nephrostomy tube (nephrostomy and suprapubic catheters are external urinary drainage systems. The primary difference is their anatomical location: a nephrostomy tube drains urine directly from the kidney through lower back, while a suprapubic catheter is inserted directly into the bladder through a small incision in the lower abdomen). Resident #38 needed partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with the following ADLs: toileting hygiene, showering/bathing, personal hygiene, lower and upper body dressing. Record review of Resident #38's Care Plan, revised on 03/03/2026, reflected [Resident #38] required indwelling Foley Catheter due to obstructive Uropathy 2nd to penile (obstructive uropathy or urethral stricture, where a physical blockage in the penis or urethra restricts urine flow) and scrotal swelling and he occasionally incontinent of bowel. Potential for UTI. Potential for constipation. Approach: Provide incontinent care promptly when found wet/soiled and make sure clothes/linens are clean, dry, wrinkle free: change PRN. The care plan also revealed [Resident #38] had impaired cognitive functioning BIMS score 10 with deficits in orientation and recall. Approach: Observe for and report changes in cognitive status. Orient to surroundings, staff, environment, ADL needs and activities. During an observation of perineal care with indwelling catheter on 06/03/2026 at 8:14 a.m., CNA D and CNA E were providing incontinent care to Resident #38. CNA D and CNA E did not pull the privacy curtain therefore exposing Resident #38 who was nude from the waist down. Resident #38's roommate Resident #99 was in his bed, and he was looking at his cell phone during the incontinent care. During an interview on 06/03/2026 at 8:55 a.m. with Resident # 38 he stated that he did not feel ok when the privacy curtain was not closed while staff were cleaning his private parts because someone could enter the room. He stated that his roommate also could see him being exposed. Resident # 38 stated that staff rarely pulled the privacy curtain when they were changing him or his roommate. He stated he wanted staff to pull the curtain every time he was provided with incontinent care. He said it upset him when staff changed him and did not pull the curtain closed. During an interview on 06/04/2026 at 8:32 a.m., with DON she stated that she had been working in the facility for 2.5 years. She stated she had been trained in resident rights. DON stated the policy was that staff were to have the curtain pulled to provide privacy when providing incontinent care. She stated that most of the privacy curtains in the residents' rooms are not working, that is why the staff did not provide privacy while providing incontinent care for Resident #38. She stated that whoever (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided care to the residents was responsible for providing privacy. She stated if staff did not provide privacy during incontinent care the residents may feel embarrassed, and it is dignity issue. She stated that the facility did order new curtains and privacy curtains accessories and all non-working curtains will be fixed. During an interview on 06/04/2026 at 8:54 a.m. with CNA E she stated she had been trained in providing incontinent care and resident rights. She stated that she had an incontinent care in service last week. She could not recall when she had the resident right training last time. She stated that pulling curtains and providing privacy during incontinent care was resident's rights and it was important to respect resident's dignity; resident did not want to be exposed to his roommate or to someone who comes into his room during incontinent care. She stated if staff did not provide privacy to the residents, the residents may feel exposed or unsafe. She stated she was assisting CNA D during incontinent care, and she thought that the curtains did not move because the moving parts were broken. She stated that she did not know why CNA D did not attempt to pull the privacy curtain. ^ During an interview on 06/04/2026 at 9:04 a.m. with CNA D he stated he had been trained in resident rights. He said he did not remember what was covered in the training. He stated he had been trained on incontinent care. He stated his last incontinent care in service training was within two weeks. He stated the policy for providing privacy when providing incontinent care was that staff were to pull the privacy curtain before starting providing incontinent care. He stated that providing privacy during incontinent care was very important because someone who entered the room could see residents' private parts. It could make them feel bad. He stated all staff were responsible for providing the residents with privacy. He stated that he did not pull the privacy curtain because he thought it was not working but the privacy curtain worked when he checked it out later. During an interview on 06/04/2026 at 1:32 p.m. with ADON she stated that it was her second year working in the facility. She stated that the facility provided an incontinent care in service last week. ADON could not recall when she had resident rights training last time. She stated that providing privacy during incontinent care was important to maintain residents' dignity. ADON stated that staff were expected to provide privacy during incontinent care. She stated she did not know why CNA D did not provide privacy for the resident at the time of care. She stated that resident could feel embarrassed because his roommate or someone who entered his room during care could see his private parts. She stated that all staff were responsible for maintaining residents' dignity. During an interview on 06/04/2026 at 3:17 p.m. with the RNC she stated that she had been trained in resident rights. She stated the policy was that all staff were to provide privacy to the residents when giving care. She said the DON, ADON and administration team monitored to ensure staff was providing privacy when doing incontinent care. She stated that if residents were cognitive, it would affect residents negatively, and the residents would feel embarrassed if staff did not provide privacy during incontinent care. During an interview on 06/04/2026 at 4:25 p.m. with ADM she stated she had been working in the facility for 2 years. She stated that she used to be a CNA and she was familiar with providing incontinent care to residents. She stated her expectation was that staff provide the residents with privacy while providing incontinent care. She stated that residents may feel embarrassed or even depressed if privacy was not provided during incontinent care. ADM stated that it was nurses', DON's, and ADON's responsibility to ensure staff was providing privacy during incontinent care. She stated that the facility ordered new curtains to replace the current curtains in the residents' rooms. ^ Record review of the facility's document titled, Catheter Care, Urinary policy dated 2001 and revised on 09/2014 revealed: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Steps in the Procedure: 1. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. Wash and dry your hands thoroughly. Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach. If the resident's physical or medical condition permits, assist the female resident on her back with knees bent and feet flat or the male resident on his back position. Refer to the resident's plan of care and/or request information from the Nurse Supervisor regarding safe positioning for the resident. Put on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves. Place bed protector under resident. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. Pour water down the commode. Flush the commode. Place soiled linen into designated container. Put on clean gloves. Remove gloves and discard into the designated container. Wash and dry your hands thoroughly. Provide privacy. Cover the resident with a sheet, exposing only the perineal area. Record review of the facility's document titled, Resident Rights policy dated 2001 and revised on 12/2016 revealed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence. b. be treated with respect, kindness, and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #38) of 1 resident reviewed for incontinent care with foley catheter. The facility failed to ensure Resident #38's catheters' drainage bag was positioned lower than Resident's urinary bladder to prevent urine from flowing back to urinary bladder. This failure could place residents at risk of UTI and other serious infections. Findings included:Record review of Resident #38's undated face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Heart failure, unspecified (heart cannot pump enough blood to meet the body's needs, but the exact type such as systolic or diastolic is not yet determined), obstructive and reflux uropathy, unspecified (urinary tract blockage or urine flowing backward into the kidneys. The root cause is not currently specified), Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (dementia symptoms such as memory loss and cognitive decline but a doctor cannot definitively determine the exact underlying cause without exhibiting behavioral, psychotic, mood, or anxiety disturbances), age-related physical debility (geriatric syndrome characterized by a loss of muscle mass, decreased physiological reserve, and increased vulnerability to stressors). Record review of Resident #38's Comprehensive MDS Assessment, dated 03/05/2026, reflected Resident #38ˆhad a BIMS score of 07 indicating severe cognitive impairment.ˆResident #38 had indwelling catheter, including suprapubic catheter and nephrostomy tube (suprapubic and nephrostomy tube catheters are external urinary drainage systems. The nephrostomy tube drains urine directly from the kidney through lower back, while a suprapubic catheter is inserted directly into the bladder through a small incision in the lower abdomen). Resident #38 needed partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with the following ADLs: toileting hygiene, showering/bathing, personal hygiene, lower and upper body dressing. Record review of Resident #38's Care Plan, revised on 03/03/2026, reflected [Resident #38] required indwelling Foley Catheter due to obstructive Uropathy 2nd to penile and scrotal swelling and he occasionally incontinent of bowel. Potential for UTI. Potential for constipation. Approach: Provide incontinent care promptly when found wet/soiled and make sure clothes/linens are clean, dry, wrinkle free: change PRN. Urine collection bag to be kept below level of bladder. Privacy bag in place on wheelchair and/or bed at all times. Foley collection bag to be kept off of the floor at all times. Monitor for signs and symptom of UTI. The care plan also revealed [Resident #38] had impaired cognitive functioning BIMS score 07 with deficits in orientation and recall. Approach: Observe for and report changes in cognitive status. Orient to surroundings, staff, environment, ADL needs and activities. During an observation of perineal care with indwelling catheter on 06/03/2026 at 8:14 a.m. Resident #38 had a urine collection bag that was hanging on the left side of the resident's bed frame and was below the resident's bladder. CNA D stated that he just emptied Resident 38's urine collection bag. He removed the urine collection bag from the resident's bed frame, placed it inside of a clear plastic bag and put it on the resident's bed, next to his left leg. The Foley bag was on the level of the resident's bladder. Further observation revealed Resident #38's Foley catheter had a yellow-colored urine inside, and the urine was moving from the middle of the catheter to the insertion site at the resident's penis during repositioning of the resident from his back to his right side. The Foley bag remained on the bed until the incontinent care was completed During an interview on 06/03/2026 at 8:55 a.m. with Resident # 38 he stated he was not aware that the Foley bag must be kept below his bladder. He stated that he did not want to get any infections. Resident # 38 stated that his indwelling foley catheter will be removed soon because he had a care plan meeting a few days ago and this was (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed during the meeting. During an interview on 06/04/2026 at 8:32 a.m., with DON she stated that she had been working in the facility for 2.5 years. DON stated that resident's Foley bag was to be placed inside of the protective plastic bag and to be placed on the residents' bed during incontinent care. She stated that placing Foley bag on resident's bed was to prevent the indwelling catheter from yanking it out of the resident's body. She stated that she told CNA D to empty Resident #38's Foley bag, protect it by covering with a plastic bag and place it on his bed. She stated that in this case the indwelling catheter was not compromised during repositioning the resident. She stated that she did not feel that resident could potentially get an infection because the urinary bag was empty and it was below his bladder. During an interview on 06/04/2026 at 8:54 a.m. with CNA E she stated she had been trained in providing incontinent care for the residents with foley bags. She stated that her last incontinent care in service was last week. She stated that residents' foley bag must be placed below the residents' kidneys and bladder because residents were at risk of getting UTIs. She stated that she was assisting CNA D during incontinent care provided for Resident #38. She stated that the resident's Foley bag was emptied prior to providing incontinent care for the resident and she did not notice the urine inside of the indwelling catheter. During an interview on 06/04/2026 at 9:04 a.m. with CNA D he stated he had been trained in providing incontinent care with indwelling catheter. He stated his last incontinent care in service training was within two weeks. CNA D stated that the foley bag should be placed below the resident's bladder to prevent backflow of the urine to the resident's body and potentially getting a UTI. CNA D stated that it was his mistake that Resident #38's Foley bag was placed on the resident's bed. During an interview on 06/04/2026 at 1:32 p.m. with ADON she stated that it was her second year working in the facility. She stated that the facility provided an incontinent care in service last week. ADON stated that Foley bag was supposed to be kept below the resident's bladder because the urine in Foley bag and catheter could back flow into resident's bladder and resident could get a UTI. ADON stated she was not aware that CNA D kept Resident #38's Foley bag on his bed during incontinent care and she did not know the reason for keeping it on the bed. During an interview on 06/04/2026 at 3:17 p.m. with the RNC she stated that staff was expected to keep the Foley bag below resident's bladders at all the time because the urine inside of the Foley bag could go back to the resident's bladder and put resident at risk for infection. During an interview on 06/04/2026 at 4:25 p.m. with ADM she stated she had been working in the facility for 2 years. She stated that she used to be a CNA and she was familiar with providing incontinent care to residents. She stated her expectation was that staff kept residents' Foley bags below residents' bladders to prevent back flow of urine and potentially causing residents to get infections, UTIs and being hospitalized . Record review of the facility's document titled, Catheter Care, Urinary policy dated 2001 and revised on 09/2014 revealed: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clamp to the catheter. 3. 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. Findings included: Record review of Resident #38's undated face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Heart failure, unspecified (heart cannot pump enough blood to meet the body's needs, but the exact type such as systolic or diastolic is not yet determined), obstructive and reflux uropathy, unspecified (urinary tract blockage or urine flowing backward into the kidneys. The root cause is not currently specified), Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (dementia symptoms such as memory loss and cognitive decline but a doctor cannot definitively determine the exact underlying cause without exhibiting behavioral, psychotic, mood, or anxiety disturbances), age-related physical debility (geriatric syndrome characterized by a loss of muscle mass, decreased physiological reserve, and increased vulnerability to stressors). Record review of Resident #38's Comprehensive MDS (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment, dated 03/05/2026, reflected Resident #38ˆhad a BIMS score of 07 indicating severe cognitive impairment.ˆResident #38 had indwelling catheter, including suprapubic catheter and nephrostomy tube (suprapubic and nephrostomy tube catheters are external urinary drainage systems. The nephrostomy tube drains urine directly from the kidney through lower back, while a suprapubic catheter is inserted directly into the bladder through a small incision in the lower abdomen). Resident #38 needed partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with the following ADLs: toileting hygiene, showering/bathing, personal hygiene, lower and upper body dressing. Record review of Resident #38's Care Plan, revised on 03/03/2026, reflected [Resident #38] required indwelling Foley Catheter due to obstructive Uropathy 2nd to penile and scrotal swelling and he occasionally incontinent of bowel. Potential for UTI. Potential for constipation. Approach: Provide incontinent care promptly when found wet/soiled and make sure clothes/linens are clean, dry, wrinkle free: change PRN. Urine collection bag to be kept below level of bladder. Privacy bag in place on wheelchair and/or bed at all times. Foley collection bag to be kept off of the floor at all times. Monitor for signs and symptom of UTI. The care plan also revealed [Resident #38] had impaired cognitive functioning BIMS score 07 with deficits in orientation and recall. Approach: Observe for and report changes in cognitive status. Orient to surroundings, staff, environment, ADL needs and activities. During an observation of perineal care with indwelling catheter on 06/03/2026 at 8:14 a.m. Resident #38 had a urine collection bag that was hanging on the left side of the resident's bed frame and was below the resident's bladder. CNA D stated that he just emptied Resident 38's urine collection bag. He removed the urine collection bag from the resident's bed frame, placed it inside of a clear plastic bag and put it on the resident's bed, next to his left leg. The Foley bag was on the level of the resident's bladder. Further observation revealed Resident #38's Foley catheter had a yellow-colored urine inside, and the urine was moving from the middle of the catheter to the insertion site at the resident's penis during repositioning of the resident from his back to his right side. The Foley bag remained on the bed until the incontinent care was completed During an interview on 06/03/2026 at 8:55 a.m. with Resident # 38 he stated he was not aware that the Foley bag must be kept below his bladder. He stated that he did not want to get any infections. Resident # 38 stated that his indwelling foley catheter will be removed soon because he had a care plan meeting a few days ago and this was discussed during the meeting. During an interview on 06/04/2026 at 8:32 a.m., with DON she stated that she had been working in the facility for 2.5 years. DON stated that resident's Foley bag was to be placed inside of the protective plastic bag and to be placed on the residents' bed during incontinent care. She stated that placing Foley bag on resident's bed was to prevent the indwelling catheter from yanking it out of the resident's body. She stated that she told CNA D to empty Resident #38's Foley bag, protect it by covering with a plastic bag and place it on his bed. She stated that in this case the indwelling catheter was not compromised during repositioning the resident. She stated that she did not feel that resident could potentially get an infection because the urinary bag was empty and it was below his bladder. During an interview on 06/04/2026 at 8:54 a.m. with CNA E she stated she had been trained in providing incontinent care for the residents with foley bags. She stated that her last incontinent care in service was last week. She stated that residents' foley bag must be placed below the residents' kidneys and bladder because residents were at risk of getting UTIs. She stated that she was assisting CNA D during incontinent care provided for Resident #38. She stated that the resident's Foley bag was emptied prior to providing incontinent care for the resident and she did not notice the urine inside of the indwelling catheter. During an interview on 06/04/2026 at 9:04 a.m. with CNA D he stated he had been trained in providing incontinent care with indwelling catheter. He stated his last incontinent care in service training was within two weeks. CNA D stated that the foley bag should be placed below the resident's bladder to prevent backflow of the urine to the resident's body and potentially getting a UTI. CNA D stated that it was his mistake that Resident #38's Foley bag was placed on the resident's bed. During an interview on 06/04/2026 at 1:32 p.m. with ADON she stated (continued on next page)

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Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that it was her second year working in the facility. She stated that the facility provided an incontinent care in service last week. ADON stated that Foley bag was supposed to be kept below the resident's bladder because the urine in Foley bag and catheter could back flow into resident's bladder and resident could get a UTI. ADON stated she was not aware that CNA D kept Resident #38's Foley bag on his bed during incontinent care and she did not know the reason for keeping it on the bed. During an interview on 06/04/2026 at 3:17 p.m. with the RNC she stated that staff was expected to keep the Foley bag below resident's bladders at all the time because the urine inside of the Foley bag could go back to the resident's bladder and put resident at risk for infection. During an interview on 06/04/2026 at 4:25 p.m. with ADM she stated she had been working in the facility for 2 years. She stated that she used to be a CNA and she was familiar with providing incontinent care to residents. She stated her expectation was that staff kept residents' Foley bags below residents' bladders to prevent back flow of urine and potentially causing residents to get infections, UTIs and being hospitalized . Record review of the facility's document titled, Catheter Care, Urinary policy dated 2001 and revised on 09/2014 revealed: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clamp to the catheter. 3. 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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately equip to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from each resident's bedside for 2 of 32 residents (Residents #53 and 84) reviewed for call system. The facility failed to ensure Residents #53 and 84 had functioning nurse call buttons on 06/02/2026, 06/03/2026, and 06/04/2026. This failure placed residents at risk of not having their needs met.Findings included: Review of the undated face sheet for Resident #53 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it), hemiplegia and hemiparesis (paralysis on one side of the body), history of falling, lack of coordination, muscle weakness, abnormalities of gait and mobility, and need for assistance with personal care. Review of the quarterly MDS for Resident #84 dated 04/16/2026 reflected a BIMS score of 14, indicating intact cognition. Review of the care plan for Resident #53 dated 04/21/2026 reflected the following: PROBLEMResident requires assistance for ADL and mobility tasks due to CVA with residual Right Dominant Hemiplegia, generalized weakness, impaired balance.GOALResident will be clean / well-groomed / appropriately dressed, will have mobility needs met and will maintain highest practical level of functional ability X 90.APPROACHKeep call light within reach. Encourage/remind resident to use bell to call for assistance. Check on resident at routine intervals to assess needs, monitor safety issues and offer/provide assistance as needed. Review of the undated face sheet for Resident #84 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type II diabetes mellitus (disease caused by the body's inability to properly use sugar), congestive heart failure (chronic condition in which the heart muscle is unable to pump enough blood to supply the entire body), history of falling, hemiplegia and hemiparesis (paralysis on one side of the body), and repeated falls. Review of the quarterly MDS for Resident #84 dated 04/16/2026 reflected a BIMS score of 10, indicating moderate cognitive impairment. It reflected he was independent with all transfers and ambulation. Review of the care plan for Resident #84 dated 04/21/2026 reflected the following: PROBLEMResident is independent for ADL and mobility tasks. Potential for unavoidable decline due to generalized weakness and chronic low back pain.GOALResident will be clean / well-groomed / appropriately dressed, will have mobility needs met and will maintain highest practical level of functional independence X 90 days.APPROACHEncourage/remind resident to use bell to call for assistance. Check on resident at routine intervals to assess needs, monitor safety issues and offer/provide assistance as needed. Observation and interview on 06/02/2026 at 1:14 PM revealed Resident #84 stated his call button was not working. He pulled it out, pressed the button, and the light did not come on outside the door or an alarm at the nurse's station. Resident #84 stated he had reported it was out to someone, but he did not remember who. He stated the button had just been out that morning. He stated there had not been any unmet needs as a result of the button not working, but he did occasionally need it. Resident #53 entered the room during the observation and stated his call button also did not work. A test of Resident #53's call button revealed the light did not come on outside the room and an alarm did not sound at the nurse's station. Observation and interview on 06/03/2026 at 10:31 AM revealed Resident #84's call button was still not working. He stated it had not worked since the day prior, but he had not needed it. Resident #53's call button was also not working. He stated he had been checked on and had not tried to use the call button since the day prior. LVN C entered the room and checked the call buttons, noticing they did not work. She left the room and returned five minutes later with two handbells. She gave a hand bell to Resident #53 and one to Resident #84. Observation and interview on 06/04/2026 at 9:27 AM revealed Resident #53 tested his call button, which did not activate the light outside his room. He stated he had tried to ring (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his bell overnight and no one had responded, and his bed was soaked in urine when he woke up. He rang his hand bell, and NA I, who was standing in the hall, did not respond. NA I stated she had not heard the handbell when it rang. During an interview on 06/04/2026 at 1:10 PM, NA J stated she had helped Resident #53 wake up that morning, and his brief was very saturated, but she had spoken to the aide who worked overnight who stated she had tried to check and help change Resident #53 several times, but he would not wake up. She stated she did know the handbells were in use as call bells for Resident #53 and 84, but she did not know if she could have heard them, because she did not think they had used the bells while she was working. During an interview on 6/4/26 at 1:19 PM using a telephone interpreter, NA I stated she had worked at the facility for three months and was in a nurse aide training class to obtain her certification. She stated she was aware of the broken call buttons in Resident #53 and 84's room. She stated nobody had a conversation with her letting her know that the call system had been temporarily replaced by handbells. During an interview on 06/04/2026 at 1:28 PM, LVN C stated she told the aides on the hall the day prior (06/03/2026) that Resident #53 and 84's call buttons had been temporarily replaced by handbells. She stated she specifically told NA I. When asked how she ensured NA I understood the instructions since she did not speak very much English, LVN C stated she thought the call button was working again, because midday she went in and pushed it, and it had worked. She stated she reported the broken call buttons to the MAINTD on 06/03/2026, and he had already known about them. During an interview on 06/04/2026 at 3:13 PM the MAINTD stated he did not know if staff had been in-serviced on the use of handbells for Resident #53 and 84. He stated he had not heard from the nursing staff that the call buttons were out but was told about it by Resident #53 on the morning of 06/02/2026. He stated he had gone into the room and tried to replace the call buttons with ones that did work, but that method was not successful. He stated he had figured out the problem was that staff were wrapping the cords around bed frames to make them accessible, but this was causing a short at the panel where they connected with the wall. He stated after he started fixing the call buttons and he did not speak with the nurse, but she came to him the following day and asked if Residents #53 and 84 had handbells. He stated it was his responsibility to ensure the call system was functional for all residents' rooms. He stated he would have to come up with a system for monitoring for compliance. He stated the potential negative impact of the call system not functioning in a resident room was that the resident might not get the help they needed. During an interview on 06/04/2026 at 3:31 PM, the DON stated the person responsible for ensuring the resident call system was the MAINTD, but the floor staff was responsible for identifying it. She stated the residents should each have had functioning methods of calling the nursing staff to their bedsides, and they had bells as a back up plan. She stated she had not done any training for staff on how to listen for handbells when the call buttons did not work. She stated a potential negative impact of the call bells or call buttons not working was residents would not be able to alert staff to get the help they needed. During an interview on 06/04/2026 at 4:00 PM, the ADM stated the responsibility for the call system was ultimately hers, but it was also overall the responsibility of anyone who discovered it was not working to enter it into the maintenance log. She stated the nursing and maintenance staff knew to place a bell at the resident's bedside if the call button was not working. The ADM stated she monitored for compliance with the process by in-servicing regularly. She stated the potential negative impact of not having a way to call for staff could be vast such as fall injuries or delay of care.Review of facility policy dated October 2010 and titled Answering the Call Light reflected the following: PurposeThe purpose of this procedure is to respond to the resident's requests and needs.General GuidelinesExplain the call light to the new resident.Demonstrate the use of the call light.Ask the resident to return the demonstration so that you will be sure that the resident can operate the system. (Note: Explain to the resident that a call system is also located in his/her bathroom. Demonstrate how it works.)Be sure that the call light is plugged in at all times.When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Some residents may not be able to use their call light. Be sure you check these residents frequently.Report (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all defective call lights to the nurse supervisor promptly.Answer the resident's call as soon as possible.Be courteous in answering the resident's call.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675918	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility for 1 of 4 required postings (survey results) reviewed. The facility failed to ensure the results of the recertification survey dated 12/31/2026 were present in the survey inspection results binder on 06/02/2026 and 06/03/2026. This facility placed residents and their responsible parties at risk of not being able to inspect survey results. Findings included: Review of the survey event database utilized by HHSC to track surveys reflected the facility was a special focus facility, indicating there would be two full recertification surveys every calendar year. It also reflected the most recent full recertification survey was 12/31/2025. Observation on 06/02/2026 at 10:45 AM revealed a white binder on the shelf behind the reception desk, in a placement reachable to passersby, including those in wheelchairs, with the title Survey Inspection Results on the jacket. Within the book were surveys dating back to 2022, and the most recent was dated 07/31/2025. Observation on 06/03/2026 at 1:13 PM revealed the survey results binder was still lacking the survey results from 12/31/2025. During a confidential group interview, five anonymous residents stated they did not know how to view the results of previous surveys. Three of them stated they would like to view the results of the most recent survey. During an interview on 06/04/2026 at 4:00 PM, the ADM stated she had worked through a survey readiness checklist on 05/11/2026 and the results were not there on that day, so she printed them and put them in the book. She stated she could not say what happened, but someone must have removed the results from 12/31/2025. She stated she was responsible for ensuring the most recent survey results were posted for the public, and her habit was to place the results right after survey.She stated a potential negative impact of the most recent results not being available was if a resident wanted to see outcomes or previous history, they would not be able to access it. She stated she knew some residents were able to look up results online. Review of facility policy dated 12/2016 and titled Resident Rights reflected the following: Policy StatementEmployees shall treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: w. examine survey results.