

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  The Arbour at Westminster Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  4200 Jackson Ave Austin, TX 78731	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</b></p> <p>Based on observation, interview and record review, the facility failed to ensure residents had the right to receive services in the facility with reasonable accommodation of the resident's needs and preferences for 1 of 8 residents (Resident #59) reviewed for accommodation of needs.</p> <p>The facility failed to ensure Resident #59's call light button was within her reach to call for nursing assistance.</p> <p>This failure placed residents at risk of having their needs gone unmet.</p> <p>Findings included:</p> <p>Record review of Resident #59's AR, dated 9/10/2024, reflected a [AGE] year-old female, born on 03/05/1933, who admitted to the facility on [DATE]. She was diagnosed with Fracture of T-11-T12 Vertebra (which was a fracture in the lower spine,) Fracture of Sacrum (which was a fracture of the large triangle shaped bone at the bottom of the spine,) and Repeated Falls (which was a medical code, utilized in diagnosing, to describe numerous past falls and future risk of falls.)</p> <p>Record review of Resident #59's Admission MDS, dated [DATE], reflected the resident had a BIMS Score of 8. A BIMS Score of 8 indicated the resident had moderate cognitive impairment. Resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand;) Resident had no impairment in either lower extremity (hip, knee, ankle, and foot;) Resident utilized a wheelchair for mobility. Resident required supervision or touching assistance with eating, oral hygiene, and personal hygiene (which meant the helper provided verbal ques, touching, steadying, or contact guard assistance while the resident completed the activity.) Resident was dependent for toileting hygiene, showering/bathing self, upper body dressing, lower body dressing and putting on/taking off shoes (which meant the helper provided all the effort of the activity.) Resident required partial/moderate assistance to walk 10 feet (which meant the helper provided less than half the effort while the resident completed the greater portion of the activity.) Resident was frequently incontinent of bladder. Resident was always incontinent of bowel.</p> <p>Record review of Resident #59's CCP reflected the following problem areas:</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Fall risk, initiated on 8/1/2024, and was evidenced by new admission, recent hospital stay, and a recent illness. The Goals, initiated on 8/1/2024, reflected the resident was supposed to be free from falls, and injury, over the next 90 days. The Intervention, initiated 8/1/2024, reflected nursing home staff was supposed to place call light within resident's reach.</p> <p>* Injuries of the back, initiated on 9/10/2024, and was evidenced by fractures of the vertebra and sacrum. The Goals, initiated on 9/10/2024, reflected the resident was supposed to be free from injury, and complication, by the target date of 12/9/2024. The Intervention, initiated on 9/10/2024, reflected nursing home staff was supposed to anticipate the resident's needs and be sure the call light was within resident's reach and responded to promptly.</p> <p>Observations and interview on 09/10/24 at 3:16 PM in Resident #59's room reflected the resident sitting in her wheelchair watching television. She was facing the television, which was at her 12 o'clock position. Observation reflected the resident's bed, the footboard area, was next to her on her right side at the 3 o'clock position. Resident #59's call light button was wrapped around the bed's stability bar, on the opposite side of her bed, near the headboard, at her 5 o'clock position. Resident #59 stated when she needed help, she could use the call button, but she was unable reach or move herself close enough to grab it. She thought the call light should have been closer for her to use. She stated she used to button to call for help if she needed to use the toilet, or be changed; and, stated she would have felt undignified if she had a toileting accident and was left wet or soiled. If she were in pain, and could not call for help, she stated she would have felt isolated and ignored.</p> <p>Interview on 9/13/2024 at 10:07 AM with CNA M revealed residents had a call light in the room in case they needed to call for help, such as restroom visits, getting an item for them, or general care. When the resident was in the room, the call light was supposed to kept within arm's reach, or nearer, preferably clipped to their pillow, blanket, or chair. If a resident did not have access to their call light, they risked falls, being left soiled, skin breakdown, feeling helpless, or feeling isolated. Measures in place to ensure a resident had access to their call light were room rounds, every 1 to 2 hours, where call light placement was supposed to be confirmed, or corrected. The failure for the resident to have their call light in reach was staff duty oversight.</p> <p>Interview on 9/13/2024 at 11:53 PM with the DON revealed call lights were utilized in resident's rooms for residents to call for staff assistance. Staff was trained staff to make sure the call light was within a resident's reach. If a resident was not able reach the call light to call for assistance, that resident risked having their needs gone unmet.</p> <p>Interview on 9/13/24 at 1:08 PM with the CADM revealed her staff trained was trained on the call light button use, and placement, per facility policy. The CADM's expectation for staff was to have ensured each resident's call light button was within reach, for those who were capable to use it, as to call for assistance. Examples of instances when a resident may have used their call light button were to use the bathroom, ask for a snack, or a general need for care. If a resident was unable to reach their call light button, they risked having their needs gone unmet.</p> <p>Record review of the facility's Answering the call Light Policy, dated October 2010, reflected the resident's call light button was supposed to be within easy reach, whether the resident was in bed, or confined to a chair.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the resident had the right to be free from abuse for one resident (Resident #44) of six residents reviewed for freedom from abuse.</p> <p>The facility failed to protect Resident #44 from an aggressive family member with suspected history of abuse. On 08/03/2024 at about 6:30pm, during the dinner, the family member shouted at Resident #44 and forcefully fed her against her will by putting the spoon with food in her mouth, as witnessed by staff members.</p> <p>On 09/24/24 at 4:36 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/25/24, the facility remained out of compliance at a scope of isolated and a severity J level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure placed the residents at risk for mental and physical harm.</p> <p>Findings included:</p> <p>Review of Resident #44's face sheet dated 09/12/24 reflected, Resident #44 was admitted to the facility on [DATE]. She was an [AGE] year-old female diagnosed with aftercare following joint replacement surgery, Cognitive communication deficit, Unsteadiness on feet, Muscle weakness, Pain in right shoulder and Dementia.</p> <p>Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected the facility was unable to complete BIMS. MDS indicated Resident #44 had some difficulty to make decisions only in new situations. She did not have any symptoms of psychosis, and no unusual behaviors were indicated.</p> <p>Record review of Resident #44's care plan dated 09/09/24 revealed the plan of structured visits of her FM, developed in the IDT meeting conducted on 08/06/24, was not incorporated into the care plan .</p> <p>Record review of facility's investigation report dated 08/06/2024 on the incident of forceful feeding and shouting involving Resident #44 and her FM on 08/02/2024 at 6:30 pm in the dining hall, confirmed the occurrence of the abuse.</p> <p>Record review on 09/24/24 of the written statement of the incident by DA E dated 08/03/24 revealed Resident #44's FM insisted her to consume the food items she did not want. DA E stated she heard a scream from the dining room when only Resident #44 and FM were there, after everyone finished dinner and left. DA E stated she heard Resident #44's FM raising his voice at her. However, since DA E was far away, she could hear only Resident #44 telling him to hush.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/12/24 at 2:46 PM, the CADM stated Resident #44's POA reported to the facility, during the admission, that there was abusive history with FM while Resident #44 was living with him in the community, with APS involvement. The CADM said she conducted a meeting on 08/06/24 with Resident #44's FM, Ombudsman, and the POA of Resident #44. In the meeting, it was decided to welcome Resident #44's FM to visit her during the restricted hours. As per this plan, the FM was allowed to visit daily from 2:00pm - 4:00pm or 3:00pm - 5:00pm in the common areas or participate in activities with Resident #44, to make every visit more enjoyable than stressful for Resident #44. She said Resident #44's FM could not visit her in her room due to his history of abusive behavior. The CADM stated Resident #44 had issues with dementia and might permit him to her room without remembering his abusive behaviors in the past. When the surveyor pointed out the absence of a care plan related to this arrangement for Resident #44's visits, for about a month after the decision being taken, the CADM stated she would add the plan to the care plan with immediate effect. She stated their plan for Resident #44's FM's visits were documented nowhere in the system. CADM said his visit was electronically monitored by her and explained that when the FM signed in at the facility, she would get an electronic notification on her mobile and then CADM would let the staff know about his arrival. When the surveyor asked what if CADM was away from her mobile phone when the FM arrived at the facility, she stated that there was a very rare chance for that. The CADM stated two other staff members from the administrative team had similar features on their mobile phone and they would be able to give directions to the staff</p> <p>Interview on 09/24/24 at 12:30 pm with the CADM and record review of Resident #44's care plan dated 09/12/24 revealed Resident #44's FM was allowed to visit daily from 2:00 pm - 4:00 pm or 3:00 pm - 5:00 pm in common areas or participate in activities with Resident #44, and he could not visit in her room. CADM stated this care plan was added on 09/12/24, after the HHSC surveyor pointed out the absence of a careplan related to the restricted visit of Resident #44's FM.</p> <p>During an interview on 08/11/24 at 10:00 am, Resident #44 stated she was married for [AGE] years and like to see FM every day. When asked about the incident that occurred in the dining room, she stated that was a month ago, and currently the visits occurred outside her room. She stated they spent time together with playing board games and chatting. She said there was no issues after the incident occurred in the dining hall and happy with the current arrangement.</p> <p>During a telephone interview on 08/12/24 at 11:30 am, the FM stated he wanted to see Resident #44 and have dinner with her every day. He stated the facility was unfair to him by putting restriction on his visits. He stated he was trying to make her eat the whole meal severed so that she would get well faster. The FM stated he did that many times in the past when she refused to eat. He said he was not abusive and did nothing wrong, however the facility was interpreting the incident differently. FM stated his intention was to improve her health.</p> <p>During an interview on 09/24/24/ at 11:30 am, the DM stated on 08/03/24 at about 6:30 pm she was at home after her shift and got a phone call from DA D stating Resident #44's FM was shouting at Resident #44 and forcefully feeding her by putting the spoon in her mouth. The DM stated Resident #44 was screaming as if she was in pain. The DM stated she managed to get the security with the help of the receptionist. She said Resident #44's FM was escorted out of the facility by the security without any further incidents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 09/24/24 at 1:00 pm, DA D stated she witnessed the incident that happened between Resident #44 and her FM on 08/03/24 at about 6:30 pm. She stated ,after the dinner time while cleaning the dining area and the kitchen in the back with DA E, she heard Resident #44 yelling that sounded as if she was hurt or was in pain. She stated she went up front and observed Resident #44 telling her FM to shut up and kept saying stop feeding. She said, at that time, FM kept telling Resident #44 she had to eat and then forced her to eat. She stated she saw him putting the fork into her mouth and she pushed it away. DA D stated Resident #44 asked for dessert, however FM told DA D not give the desert. DA D stated when she provided the dessert, the FM told Resident #44 that she could not have the desert before finishing all the meal left in the plate. DA D stated they kept arguing, and at one point, she saw Resident #44 drying her eyes with a paper towel. DA D added that wasn't the first time she had seen him trying to force feed her. When asked why she did not report it that time, she stated she thought things would get better. However, she now realized it was going bad.</p> <p>On 09/24/24 at 1:30 pm, an attempt to have a telephone interview with DA E was unsuccessful.</p> <p>During an interview on 09/13/24 at 11:30 am, Resident #44's POA stated she had a meeting with the CADM, Resident #44's FM, and the ombudsman at the facility on 08/06/24, and they decided to have a plan for restricted and supervised visits for Resident #44's FM. She stated she agreed with this arrangement as she was aware of the long history of physical and mental abuse by him while Resident #44 was living with him in the community. The POA stated there was APS involvement in the past due to domestic violence and abusive behavior of the FM. She stated she wanted to protect Resident #44 from incidents of abuse at the facility. The POA added , at the same time, she did not want to totally cut her off from FM and found the idea of supervised visits as a useful solution to the situation.</p> <p>During an interview on 09/12/24 at 2:46 PM, the MDSC stated it was his responsibility to make changes in the care plan based on the information passed on by SW worker, DON, CADM, or other responsible parties. He stated he heard about the incident that occurred in the dining hall and the meeting thereafter. However, no one reported to him about the outcome of the meeting for care planning.</p> <p>During interview on 09/12/24 at 4:00 pm, CNA A stated she worked on Resident #44's hall. She said she was not aware of any care plan related to Resident #44's FM's visit. She stated she knew him and would allow him to meet Resident #44 in her room if he wanted, as it was part of the resident's rights policy.</p> <p>During an interview on 09/12/24 at 4:10 PM, CNA B stated Resident #44's family member was a regular visitor and would encourage him to visit her anytime if they wanted to. She said she was not aware of any specific plan for his visit.</p> <p>During an interview on 09/12/24 at 4:45 pm, the RA stated she had seen Resident #44 and her family member almost every day in the recreational area, engaged in board games. RA said she did not know why they were there instead of her room. The RA stated she would guide him to her room if he requested, or would encourage them to have meals together.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 09/24/24 at 10:55 am, MA C was administering medications to residents. She stated she generally worked on the 1st floor and occasionally works at 2nd floor where Resident #44 resides. She stated she heard from other staff members that there were restrictions on Resident #44's FM to visit her. She stated she did not know what the restricted hours and the exact plan was.</p> <p>During an interview on 09/24/24 at 11:10 am, CNA D stated she worked at the facility as PRN and was aware of some restrictions on Resident #44's FM to visit her. She stated she did not know the details about it. However, when he asked to see Resident #44 , she would redirect him to the nurse in charge.</p> <p>During an interview on 09/24/24 at 3:30 pm, DA F stated she worked at the facility part time since April 2024. She stated she knew Resident #44 and her FM, and saw them, many times, arguing . She stated she had an impression that FM was trying control Resident #44 . She stated she had seen Resident #44 trying to get away from FM during dinner times as FM took control on her and insisted her to eat the way he decided. She stated she never had seen any physical abuse from him so she thought they were not reportable. DA F stated she knew there were some restrictions on his visits, however, she did not know the visitation time or the plan for his restricted visits.</p> <p>During an interview on 09/24/24 at 3:45 pm, DA G stated she worked at the facility for about a year and knew the dynamics between Resident #44 and the FM. She stated serving food to them was always difficult as the FM demanded attention as if there were no other residents to attend to. She stated Resident #44's FM gave priority to him over Resident #44. DA G stated she had seen Resident #44 and the FM arguing while having dinner , mostly when the FM shouted at her. When the investigator asked DA G if there were any restrictions in place for Resident #44's FM's visits , she stated she was not aware of any and would serve them dinner if they wanted to eat together. She stated she had not seen the FM at dinner for while, however, she had seen them spending time together in the activity room.</p> <p>During an interview on 09/24/24 at 4:00 pm, the CADM stated Resident #44's FM visited her as per the plan without any deviation. She stated they remained in the open area so that staff could supervise. When the surveyor asked, since it was a supervised visit who was responsible for supervision during his visit, CADM stated there were no specific persons responsible as they sat in the open area and were visible to everybody.</p> <p>Record review of the in-services revealed on 08/11/24 in-services were conducted on Definition of caregiver, provider, and sitter to include staff responsibilities. Limitations of visit for [Resident #44's FM] and on 09/13/24 Visitation for [Resident #44] and [FM]. The attendance sheet reflected 8 staff members were in serviced and CNA A, CNA B , RA, MA C, DM, DA E, DA F and DA G were not participant in these in-services.</p> <p>Review of the facility's policy Reporting abuse to facility management revised February 2024 reflected:</p> <p>1.Our facility does not condone resident abuse to anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. To help with recognition of incidents of abuse, the following definitions of abuse are provided:</p> <p>a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>b. Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents; regardless of their age, ability to comprehend, or disability.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 09/24/24 at 3:00 PM. The ADM was notified and provided with the IJ template on 09/24/24 at 4:36pm.</p> <p>The following Plan of Removal submitted by the facility was accepted on 09/25/24 at 12:40 PM and reflected the following:</p> <p>Immediate Jeopardy</p> <p>On 09/10/2024 an abbreviated survey was initiated at [facility]. On 09/24/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety.</p> <p>The notification of Immediate Jeopardy states as follows: The facility failed to protect Resident #44 from an aggressive family member with behaviors.</p> <p>Action: Referral made to, for Resident #44. Will be completed on 09/25/2024.</p> <p>Start Date: 9/25/24, Completion Date: 9/25/24, Responsible: Administrator.</p> <p>Action: Social Worker to interview Resident #44 for psychosocial well-being.</p> <p>Start Date: 9/25/24, Completion Date: 9/25/24, Responsible: Administrator</p> <p>Action: Executive Director in serviced Administrator and Director of Nursing on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions.</p> <p>Start Date: 9/24/2024, Completion Date: 9/24/2024, Responsible: Executive Director</p> <p>Action: All staff in-serviced on Resident #44's visiting instructions with Resident #44's husband. In-service includes visiting hours, husband's meal restriction while visiting, and if there are any concerns during visitation to immediately inform charge nurse, ADON, DON, or Administrator. Start Date: 9/24/2024. Completion Date: on-going until all staff (nursing department, dietary department, housekeeping department, activity department, front desk) who are employed by the facility are in serviced. Responsible: Administrator</p> <p>Action: All staff not present and new staff will be in-serviced on Resident #44's visiting instructions with Resident #44's husband prior to the start of their shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Start Date: 9/24/2024,Completion Date: on-going, Responsible: Administrator</p> <p>Action: New staff, PRN and agency nursing staff will be in serviced prior to the start of their shift. Start Date: 9/24/2024,Completion Date: on-going, Responsible: Director of Nursing.</p> <p>Action: Resident #44's FM is allowed to have observed visits by staff during an agreeable time frame by Resident #44, her POA, and her husband.</p> <p>Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator.</p> <p>Action: Resident #44's POA agreed with the Resident #44's FM's visitation instructions. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator.</p> <p>Action: Resident #44 agreed with her FM's visitation instructions.</p> <p>Start Date: 9/24/2024, Completion Date: 9/24/24,Responsible: Administrator.</p> <p>Action: Resident #44's FM visitation instructions have been care planned by the Director of Nursing ensuring Resident's rights are being met. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator.</p> <p>Action: Resident #44's FM had agreed to the visitation instructions.</p> <p>Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator</p> <p>Monitoring of the Plan of Removal on 09/25/24 included the following:</p> <p>POA approved for a Referral for psychiatric assessment of Resident #44. During an interview on 09/25/24 at 12:00pm CADM reported that the team visited and assessed of Resident #44 was in progress on 09/25/24 at 12:45pm.</p> <p>During an interview on 09/25/24 at 12:00pm CADM stated the psychosocial wellbeing interview was completed by the social worker to asses her mood, on 09/25/24.</p> <p>CADM and the DON on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions.</p> <p>Record review of the employee list revealed that the facility employed about 100 staff members including PRN staff members. Review of in-service record revealed about 80 staff members were in serviced and the program was still going on.</p> <p>During an interview on 09/25/24 at 12:00pm CADM stated she texted all the PRN employees and instructed about the in service. She stated they would be able to complete the in-service sooner than later.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Arbour at Westminster Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  4200 Jackson Ave Austin, TX 78731	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/24 at 2:00pm CADM explained the structure and plan of the visits. She stated on Monday - Friday, the activities director or assistant, would either observe or designate observation of visitation in the activity room. She stated Saturday - Sunday, the weekend ADON will either observe or designate observation of visitation in the activity room.</p> <p>During an interview on 09/24/24 at 4:50 pm, the POA stated she was happy with the current arrangement of the restricted visit.</p> <p>During an interview on 09/25/24, at 10:30am Resident#44 stated she wanted her FM to visit her every day and was okay with the plan.</p> <p>Review of Resident #44's updated careplan dated 09/12/24 revealed Resident #44's FM was allowed to visit daily from 2:00 pm - 4:00 pm or 3:00 pm - 5:00 pm in common areas or participate in activities with Resident #44, and he could not visit in her room. CADM stated this care plan was added on 09/12/24, after the HHSC surveyor pointed out the absence of a careplan related to the restricted visit of Resident #44's FM.</p> <p>Record review of the in-service record on 9/25/24 revealed Executive Director in serviced on 09/24/24 the CADM and DON on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions.</p> <p>The staff from morning and afternoon shift who were interviewed on 09/25/24 stated, they had attended the in-service on the restricted visit of Resident #44's FM and were able to explain the plan in place for the restricted visit.</p> <p>The CADM was informed the Immediate Jeopardy (IJ) was removed on 09/25/24 at 3:10pm. The facility remained out of compliance at a scope of isolated and a severity J level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47772</b></p> <p>Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 10 Residents (Resident #43 and Resident #44) reviewed for care plans.</p> <p>Resident #43</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1. Resident #43's legs were elevated while sitting or sleeping.</li> <li>2. Resident #43 wore her compression stockings.</li> </ol> <p>2. Resident #43's door remained open, except when receiving care.</p> <p>Resident #44</p> <p>The facility failed to develop a comprehensive care plan that included interventions to ensure safety of Resident # 44 from the visitor's aggressive, physical, and verbal behaviors.</p> <p>This failure could place residents at risk of continued abuse, and not reaching their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Resident #43</p> <p>Record review of Resident #43's AR, dated 9/10/2024, reflected an [AGE] year-old woman, born on 12/22/1936, who admitted to the facility on [DATE]. He She was diagnosed with Peripheral Vascular Disease (which was a progressive disorder of the blood vessels, having caused narrowing, spasms, or blockage of blood vessels,) Venous Insufficiency (which was a condition having caused problems with the body's ability to channel blood flow towards the heart,) Parkinson's Disease (which was progressive disorder that affected the nervous system and the parts of the body controlled by the nerves,) Repeated Falls (which was a medical code, utilized in diagnosing, which was used do designate numerous past falls and future risk of falls, ) and Psychosis, Unspecified, (which was a classification of a non-specific disorder associated with the mind.)</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 - Few</p>	<p>Record review of Resident #43's Quarterly MDS, dated [DATE], reflected the Staff's assessment of Resident #43's cognitive skills for daily decision indicated Resident #43 was severely impaired. Resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand;) Resident had no impairment in either lower extremity (hip, knee, ankle, and foot;) Resident utilized a wheelchair for mobility. Resident required substantial/maximum assistance for eating, oral hygiene, and personal hygiene, rolling left to right (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity.) Resident was dependent for toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off shoes, sitting to lying, lying to sitting on side of bed, sitting to standing, chair to bed/ bed to chair transfer, and tub/shower transfer (which meant the helper provided all the effort of the activity.) Resident was always incontinent of bladder. Resident was always incontinent of bowel.</p> <p>Record review of Resident #43's CCP reflected the following Problem areas:</p> <p>*Functional performance, initiated on 4/1/2021. The Goal, revised on 9/9/2024, reflected the resident would have maintained functional performance through the target date of 12/8/2024. The Intervention, initiated 4/1/2021, reflected staff would provide two-person assist for bed mobility, one-person assist for personal hygiene one-person assist for toileting, and two-person assist for transfer.</p> <p>* Assist bars, initiated 7/9/2024, evidenced by the need to enable and promote independence. The Goals, revised on 9/9/2024, reflected the resident was supposed to feel more secure and independent in bed during ADLs and to minimize associated risks. The Intervention, initiated on 7/9/2024, reflected the resident was supposed to have utilized the assist bars to promote independence.</p> <p>* Peripheral Vascular Disease (PVD) initiated 10/28/2020. The Goal, initiated on 10/28/2024, reflected the resident was supposed to have remained free of complications of PVD through the target date of 12/8/2024. The Interventions, initiated on 10/28/2020, reflected nursing home staff was supposed to have elevated Resident #43's legs while sitting or sleeping and encourage resident to change positions frequently.</p> <p>* Inability to have utilized the call light button, initiated 9/10/2024, evidenced by low cognition level. The Goal, initiated on 9/10/2024, reflected the resident was supposed to have maintained cognitive function through the target date of 12/8/2024. The Interventions, initiated on 9/10/2024, reflected nursing home staff was supposed to have left Resident #43's bedroom door open, unless having received care, and having provided frequent checks while resident was in the bedroom.</p> <p>* Skin integrity, initiated on 7/17/2020, R/T chronic stasis (poor blood flow) and fragile skin. The Goals revised on 10/28/2020 reflected the resident was supposed to maintain clean and intact skin; having had no complications R/T stasis through the review date of 12/8/2024. The Intervention, initiated on 7/17/2020, delegated nursing home staff to assist in having daily applied compression stockings (which were specialized socks that applied gentle pressure to improve blood flow from the legs to the heart.) According to the CCP, the date of the last CCP review was 9/9/2024. The print date of the CCP was 9/10/2024.</p> <p>Record review of a progress note entered by Social Services, dated 9/9/2024 at 9:36 AM, reflected Resident #43 temporarily changed rooms to 1118.</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 - Few</p>	<p>Observations and interview on 09/10/24 at 3:32 PM at Residents #43's room revealed the door to the room was closed. When having entered the room, there was no staff present and care was not being provided. There was a strong odor of bowel. The bed was in the lowest position, with blue floor fall mats on both sides of the bed. Observations revealed Resident #43 sleeping in her bed. While having faced the bed from the footboard, the head rest portion of the bed, located at the 12 o'clock position, was elevated approximately 20 degrees. The resident was lying on her left side of her body, curved diagonally from left to right like the shape of a banana. Resident was lying perpendicular to the mattress. The left side of her face was resting against the mattress and pillow, facing away from the observer, at the spot where the mattress began to tilt upwards 20 degrees. Her head was at the 10 o'clock position of the bed on the far-left edge of the mattress close to the assist bar. Both of her legs, from the lower knees/upper shins area down, were hanging off the bed at the 4 o'clock position, uncovered. She was not wearing compression stockings. The positioning of her lower extremities was lower than the level of the rest of her body. There was a normal sized bed pillow under Resident #43's covers at the 5 o'clock position. Interview with RN N revealed the resident's legs had purposely been hung over the end of the bed to protect her heels from pressure ulcers; He was observed having knelt beside the resident and was observed having pointed to Resident #43's left and right heels with his finger. Initially, he stated the pillow was placed on the bed to keep the resident from bringing her legs back to the mattress, but later admitted he did not know why the pillow was there. RN M was observed having briefly exited the room to get assistance from LVN O to have helped reposition the resident. RN M and LVN O were observed having repositioned Resident #43 on her bed. Observations revealed the residents head placed at the 12 o'clock position and her feet at the 6 o'clock position with her feet elevated under the pillow that was already under her covers. Both RN M and LVN O admitted not knowing much about Resident #43's care because she just moved down from the 2nd floor, on 9/9/2024. LVN O stated Resident #43 was not positioned correctly at the time she entered the room. LVN O stated she checked on Resident #43 when she came on shift at 2:00 PM but did not know if she had been checked upon since 2:00 PM. Two CNAs had entered the room to provide resident with care.</p> <p>Interview on 9/11/2024 at 8:03 AM with CNA P revealed she had access to Resident #43's care instructions, which were found in the Kardex. The Kardex was a brief written description of Resident #43's needs, taken from her CCP. The Kardex was located on a medium sized touchscreen monitor, known as a Kiosk, located in the resident's hallway. She stated Resident #43's legs were supposed to be elevated to prevent swelling and discomfort. CNA P stated, she was unaware of the resident's need for compression stocking and did not put any on the resident.</p> <p>Interview, observation, and record review on 9/13/2024 at 10:20 AM with CNA M revealed Resident #43's care information was found on her Kardex. CNA M was observed logging into the Kiosk and having pulled up Resident #43's Kardex. The Kardex indicated Resident #43 was supposed to have her door open when not receiving care and was supposed to receive frequent checks. The Kardex did not have instructions to ensure Resident #43's legs were elevated while sitting or sleeping or to have compression stockings; however, CNA M did have access to viewing the resident's entire CCP. CNA M was observed viewing the CCP in its entirety, from the Kiosk where the elevation of legs and compression stockings were mentioned. CNA M stated she was instructed to check both the CCP and the Kardex to know the resident's needs.</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 - Few</p>	<p>Interview on 9/13/2024 at 10:40 AM with NP T, who worked at a local geriatric care provider agency, revealed PVD was a medical condition that effected circulation of blood in the extremities. The intervention of elevating someone's legs, who was diagnosed PVD, would help reduce swelling and fluid collection in the lower extremities. Without elevation, the resident risked complications with skin integrity, accumulation of fluid, pain, and discomfort in the extremity.</p> <p>Interview on 9/13/2024 at 12:07 PM with the DON revealed interventions for a resident, with a diagnosis of PVD, would be to elevate their legs, if they were showing signs or symptoms. If a resident were unable to utilize their call light, interventions would be written in the CCP. The DON stated all nursing staff had access to the resident's Kardex's, and the CCPs. The expectation of staff was that they utilized both the Kardex, and the CCP, to have known the specifics of each resident's needs.</p> <p>Interview on 9/13/24 at 1:08 PM with the CADM revealed residents who were not able utilize their call lights received alternate interventions, which were found in the resident's Kardex and CCP. The relationship between a call light button, and a resident who was able to use it, was just as important as the interventions for the resident who could not use theirs. Having deferred responses to medical questions, the CADM stated CNA staff was not trained to make medical assessments of resident's medical conditions, so they were expected to follow the care plan. From time to time, residents will move from one area of the facility to another, and care givers may change; however, unfamiliar staff were expected to know the same information about the resident. The CADM expected her staff to follow the instructions and interventions in the Kardex, and the CCP.</p> <p>Record review of the facility's Comprehensive Person-Centered Care Plan, dated March 2022, reflected each resident's comprehensive person-centered care plan was consistent with the resident's rights to receive the services and/or items included in the care plan. The comprehensive person-centered care plan described the services that were supposed to be furnished to attain, or maintain, the resident's highest practicable physical, mental, and psychosocial well-being, including which professional services were responsible for each element of care. Services provided, or arranged by the facility, were outlined in the comprehensive person-centered care plan, and were provided by qualified persons, who were culturally competent, and trauma informed.</p> <p>Record review of the facility's ADL Policy, dated March 2018, reflected appropriate care would be provided for residents who were unable to conduct ADLs independently, such as hygiene, mobility, and toileting, and communication (speech, language, and any functional communication system.) Interventions to improve, or minimize, a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.</p> <p>Record review of the facility's Call Light Policy, dated October 2010, reflected some residents may not be able to use their call light. Be sure to check these residents frequently.</p> <p>Resident #44</p> <p>Review of Resident #44's face sheet dated 09/12/24 reflected, Resident #44 was admitted to the facility on [DATE]. She was an [AGE] year-old female diagnosed with aftercare following joint replacement surgery, Cognitive communication deficit, Unsteadiness on feet, Muscle weakness, Pain in right shoulder and Dementia.</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 - Few</p>	<p>Record review of Resident #44's quarterly MDS dated [DATE] reflected the facility was unable to complete BIMS. MDS indicated Resident #44 had some difficulty to make decisions only in new situations. She did not have any symptoms of psychosis, also no unusual behaviors indicated.</p> <p>Record review of Resident #44's care plan dated 09/09/24 did not address structured visits of her family member per IDT meeting conducted on 08/06/24</p> <p>During an interview on 08/11/24 at 10:00AM Resident#44 stated she was married for [AGE] years and like to see him every day. When asked about the incident occurred in the dining room, she stated that was a month ago and currently the visit occurred outside her room. She stated they spent time together with playing board games and chatting. She said there was no issues after the incident occurred in the dining hall and happy with the current arrangement.</p> <p>Interview on 09/12/24 at 2:46 PM, the CADM stated she was informed by the POA that there was history of abusive incidents in the past while Resident #44 and family member lived in the community . The CADM said she conducted a meeting on 08/06/24 with Resident #44's family member, Ombudsman and the POA of Resident #44. In the meeting it was decided to welcome Resident #44's family member to visit her in the restricted hours. As per this plan Resident#44's husband was allowed to visit daily from 2:00pm - 4:00pm or 3:00pm - 5:00pm in the common areas or participate in activities with Resident #44, to make every visit enjoyable than stressful for Resident #44. She said Resident #44's family member could not visit her in her Room due to his abusive behavior. The CADM stated Resident #44 has issue with dementia and might permits him to her room without remembering his abusive behaviors in the past.</p> <p>During an interview Resident #44's POA stated she had a meeting with the CADM, Resident #44's husband and ombudsman at the facility on 08/06/24 and decided to have a plan for restricted and supervised visits for Resident #44's family member. She stated she agreed with this arrangement as she was aware of the long history of physical and mental abuse by him while Resident #44 was living with him in the community. She stated she wanted to protect Resident #44 from incidents at the facility as Resident #44 would not be safe if they were left alone unsupervised. The POA stated there was APS involvement in the past due to domestic violence and abusive behavior.</p> <p>Interview on 09/12/24 at 2:46 PM, the MDSC stated it was his responsibility to make changes in the care plan based on the information passed on by social worker, DON, CADM, or other responsible parties. He stated he heard about the incident occurred in the dining hall and the meeting thereafter however no one reported to him about the outcome of the meeting for care planning.</p> <p>During interview on 09/12/24 at 4:00pm CNA A stated she worked on Resident #44's hall. She said she was not aware of any care plan related to Resident #44's family member's visit. She stated she knew him and would allow him to meet Resident #44 in her room if he wanted, as it was part of the resident's rights policy.</p> <p>During an interview on 09/12/24 at 4:10PM CNA B stated Resident #44's family member was a regular visitor and will encourage him to visit her anytime if they wanted to. She said she was not aware of any specific plan for his visit.</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 - Few</p>	<p>During an interview on 09/12/24 at 4:45pm the RA stated she had seen Resident #44 and her family member almost every day in the recreational area, engaged in board games. RA said she did not know why they were there instead of her room. The RA stated she would guide him to her room if he requested or encourage to have meals together.</p> <p>During a second interview on 09/13/24 at 11:20AM, the CADM stated they should have incorporated the plan for Resident #44's family member's restricted visit in the care plan. She said his visit at the facility was going well as per the plan for the last month, without any issues however including the plan in the care plan was important for the effectiveness of the intervention. She stated it was unfortunate that staff did not know about the care plan for his visit.</p> <p>Record review of the in-services in August 2024 revealed on 08/11/24 an Inservice on Definition of caregiver, provider, and sitter to include staff responsibilities. Limitations of visit for [Resident #44's husband].</p> <p>The attendance sheet reflected CNA A, CNA B and RA were not participant in this Inservice.</p> <p>Record review of facility policy Care plans, Comprehensive Person-Centered revised in March 2022, revealed:</p> <p>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.</p> <p>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.</p> <p>2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.</p> <p>3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p>		