STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676198	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Querencia at Barton Creek	2500 Barton Creek Blvd Austin, TX 78735

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes for one (Resident #1) of nine residents reviewed for care plans. The facility failed to update Resident #1's care plan after a fall on 07/20/2025 with additional interventions to prevent another fall. The facility failed to update Resident #1's care plan after a physical therapy evaluation on 07/30/2025 determined Resident #1 should be transferred with two staff members. Resident #1 experienced a fall on 08/03/2025 and 48 hours later was diagnosed with a hip fracture from the fall and 24 hours later was in surgery for a full hip replacement. On 09/04/2025 at 12:21 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/05/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of not having their medical, nursing, mental and psychosocial needs met and ensuring safe care for each resident to prevent serious injuries. Findings included: Record review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis including other spondylosis, lumber region (refers to degenerative changes in the lower back, often leading to symptoms like pain, numbness, and weakness due to nerve compression), age related osteoporosis without current pathological fracture (condition characterized by the weaking of bones due to aging), Alzheimer's disease (progressive decline in memory, thinking, and behavior), unsteadiness on feet, muscle weakness, and fracture of left femur. Record review of Resident #1's annual MDS , dated 05/29/2025, reflected a BIMS score of 01, which indicated cognition was severely impaired. Section GG - Functional Abilities reflected Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Section H - Bladder and Bowel reflected Resident #1's urinary and bowel continence was Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Record review of Resident #1's care plan, dated 05/19/2022 and revised 06/24/2025, reflected the following, Current Functional Performance . Interventions, Resident performance: Transfer - Extensive assist/one-person physical assist. Further review of Resident #1's care plan, dated 12/14/2022 and revised on 05/12/2025, reflected the following, Resident #1 was on palliative care and request comfort care only and will remain free from pain/discomfort and live to the end of my life with dignity. Interventions Refrain from sending me to the hospital unless I (Resident #1) sustain a traumatic injury or my RP or I (Resident #1) request transfer. Further review of Resident #1's care plan reflected that the PT Evaluation & Plan of Treatment completed on 07/30/2025 did not reflect the physical therapy recommendation of a 2-person transfer outlined under Functional Assessment, Transfers = Max/2. Record review of Resident #1's incident report, dated 08/03/2025, revealed CNA A was helping Resident #1 to the restroom without the use of a gait belt and Resident #1 lost her balance as she was unable to bear weight and fell in the bathroom. LPCN B assessed Resident #1 immediately following the fall on 08/03/2025 and noted no indications of pain, conducted a skin assessment that revealed a small abrasion to L elbow 1.5 x .03 cm, vitals obtained, and responsible party was notified, and NP notified via copy of incident placed in provider box. CNA was not educated on significant change of 2x person assist as the care plan was not updated prior to care being provided. CNA A was suspended immediately pending the facility investigation and resigned from her position prior to facility concluding their investigation as she made false statements. Record review of Resident #1's Hospital Trauma Transfer Report, dated 08/05/2025, reflected the following: Admit time 07:55 PM, trauma transfer, Resident #1 presented to the ED after a fall, patient ambulates with assistance from Aide at baseline, injury was deemed to be just bruising, however x-ray done showed a left femoral neck fracture. Plan: patient will be admitted to trauma service and orthopedic surgery the morning of August 6. Record review of Resident #1's physician order, dated 07/21/2025, reflected the following: PT/OT eval and treat for fall/ADLs. Record review of Resident #1's Physical Therapy PT Evaluation & Plan of Treatment, dated 07/30/2025, reflected the following: Functional transfers PLOF (prior level of function) was CGA (contact guard assist) and Resident #1's functional transfer baseline was Max/2 (highest level of assistance required for a transfer, performed w/ minimal help or no assistance at all). During an observation on

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 9 residents reviewed for quality of care. The facility failed to notice a change in condition after Resident #1 experienced a fall on 08/03/2025 and had visible signs of pain for 48 hours before being sent to the ER for a broken hip.The facility failed to complete post-fall assessments per policy for Resident #1 which caused Resident #1 to have an untreated hip fracture for up to 48 hours before outside medical attention was sought. The facility failed to address Resident #1's pain which was evidenced by facial grimacing and other non-verbal signs of pain for 48 hours and failed to assess whether PRN Tylenol was sufficient to relieve pain caused by the fractured hip. These failures could place residents at risk of negative outcome to a resident's physical, mental, or psychosocial health or well-being Findings include: Record review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis including other spondylosis, lumber region (refers to degenerative changes in the lower back, often leading to symptoms like pain, numbness, and weakness due to nerve compression), age related osteoporosis without current pathological fracture (condition characterized by the weaking of bones due to aging), Alzheimer's disease (progressive decline in memory, thinking, and behavior), unsteadiness on feet, muscle weakness, and fracture of left femur. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 01, which indicated cognition was severely impaired. Section GG - Functional Abilities reflected Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #1's care plan dated 05/19/2022 and last revised 06/24/2025, reflected the following, Current Functional Performance. Interventions Resident performance: Transfer - Extensive assist/one-person physical assist. Further Record review of Resident #1's care plan dated 12/14/2022 and last revised on 05/12/2025, reflected the following, Resident #1 was on palliative care and request comfort care only and will remain free from pain/discomfort and live to the end of my life with dignity. Interventions Refrain from sending me to the hospital unless I (Resident #1) sustain a traumatic injury or my RP or I (Resident #1) request transfer. Further review of Resident #1's care plan reflected that the PT Evaluation & Plan of Treatment completed on 07/30/2025 did not reflect the physical therapy recommendation of a 2-person transfer outlined under Functional Assessment, Transfers = Max/2. Record review of Resident #1's MAR revealed Resident #1 was administered pain medication Tylenol PRN 325 mg two tablets as followed: 08/04/25 at 12:34 AM08/05/25 at 4:52 PM There was no documentation regarding effectiveness or pain level assessment. Record review of Resident #1's incident report dated 08/03/2025 revealed that CNA A was helping Resident #1 to the restroom and Resident #1 lost her balance and fell in the bathroom. LPCN B assessed Resident #1 and noted no indications of pain, conducted a skin assessment that revealed a small abrasion to L elbow 1.5 x .03 cm, vitals obtained, and Responsible Party was notified and NP notified via copy of incident placed in provider box. CNA A had not been notified of the resident's significant change prior to her fall on 08/03/2025. Record review of Resident #1's Hospital Trauma Transfer Report, dated 08/05/2025, reflected the following: Admit time 07:55 PM, trauma transfer, Resident #1 presented to the ED after a fall, patient ambulates with assistance from Aide at baseline, injury was deemed to be just bruising, however x-ray done showed a left femoral neck fracture. Plan: patient will be admitted to trauma service and orthopedic surgery the morning of August 6. Record review of Resident #1's physician order, dated 07/21/2025, reflected the following: PT/OT eval and treat for fall/ADLs. Record review of Resident #1's Physical Therapy PT Evaluation & Plan of Treatment, dated 07/30/2025, reflected the following: Functional transfers PLOF (prior level of function) was CGA (contact guard assist) and Resident #1's functional transfer baseline is Max/2 (highest level of assistance required for a transfer, performed w/ minimal help or no assistance at all). During an interview on 09/02/2025 at 5:41 PM, DON stated the nurses should have completed assessments for 72 hours after the fall. If the nurses had done the ROM assessment post fall, they would have discovered the broken hip sooner or noted the pain Resident #1 was experiencing. DON stated she was in-serviced last month, she completes in-services regularly with nursing managers. DON stated the policy for transferring/bathroom assisting a resident depends on assistance resident is needing, reviewing the electronic care plan, and best

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent avoidable accidents for 2 (Resident #1 and Resident #2) of 9 residents reviewed for quality of care. The facility failed to ensure CNA A used a gait belt when assisting Resident #1 with transfer on 08/03/2025 which resulted in Resident #1 falling and breaking her hip. The facility failed to ensure CNA A used two people assist with transfers as recommended on Resident #1's therapy evaluation on 07/30/2025, which determined Resident #1 should be transferred with two staff members. Resident #1 experienced a fall on 08/03/2025 and 48 hours later was diagnosed with a hip fracture from the fall. The facility failed to ensure CMA B used a gait belt when assisting Resident #2 with transfer on 09/02/2025. On 09/03/2025 at 7:17 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/05/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of avoidable accidents resulting in serious harm and injury and a decreased quality of life. Findings include: Record review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis including other spondylosis, lumber region (refers to degenerative changes in the lower back, often leading to symptoms like pain, numbness, and weakness due to nerve compression), age related osteoporosis without current pathological fracture (condition characterized by the weaking of bones due to aging), Alzheimer's disease (progressive decline in memory, thinking, and behavior), unsteadiness on feet, muscle weakness, and fracture of left femur. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 01, which indicated cognition was severely impaired. Section GG - Functional Abilities reflected Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #1's care plan dated 05/19/2022 and last revised 06/24/2025, reflected the following, Current Functional Performance. Interventions Resident performance: Transfer - Extensive assist/one-person physical assist. Further review of Resident #1's care plan dated 12/14/2022 and last revised on 05/12/2025, reflected the following, Resident #1 is on palliative care and request comfort care only and will remain free from pain/discomfort and live to the end of my life with dignity. Interventions Refrain from sending me to the hospital unless I sustain a traumatic injury or my RP or I request transfer. Further review of Resident #1's care plan reflected that the PT Evaluation & Plan of Treatment completed on 07/30/2025 did not reflect the physical therapy recommendation of a 2-person transfer outlined under Functional Assessment, Transfers = Max/2.Record review of Resident #1's incident report dated 07/20/2025 revealed Resident #1 fell but did not suffer any injuries. Resident #1's care plan was not updated after the fall. Record review of Resident #1's physician order, dated 07/21/2025, reflected the following: PT/OT eval and treat for fall/ADLs. Record review of Resident #1's Physical Therapy PT Evaluation & Plan of Treatment, dated 07/30/2025, reflected the following: Functional transfers PLOF (prior level of function) was CGA (contact guard assist) and Resident #1's functional transfer baseline is Max/2 (highest level of assistance required for a transfer, performed w/ minimal help or no assistance at all). Record review of Resident #1's PT evaluation conducted on 07/30/2025 revealed Resident #1 required two people to transfer and a gait belt. Record review of Resident #1's incident report dated 08/03/1015 revealed that CNA A was helping Resident #1 to the restroom and Resident #1 lost her balance and fell in the bathroom. LPCN B assessed Resident #1 and noted no indications of pain, conducted a skin assessment that revealed a small abrasion to L elbow 1.5 x .03 cm, vitals obtained, and Responsible Party was notified and NP notified via copy of incident placed in provider box. Record review of Resident #1's Hospital Trauma Transfer Report, dated 08/05/2025, reflected the following: Admit time 07:55 PM, trauma transfer, Resident #1 presented to the ED after a fall, patient ambulates with assistance from Aide at baseline, injury was deemed to be just bruising, however x-ray done showed a left femoral neck fracture. Plan: patient will be admitted to trauma service and orthopedic surgery the morning of August 6. Record review of Resident #2's face sheet dated 09/05/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including arthritis (inflammation of the joints), dementia (loss of cognitive functioning), major depressive