

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Querencia at Barton Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record, and indicate the duration for the PRN order for 1 of 3 residents (Resident #11) reviewed for pharmacy services .</p> <p>The facility failed to ensure Resident #11 had a stop date for PRN Alprazolam (a medicine used to treat the symptoms of anxiety)</p> <p>This failure could affect residents who received antipsychotic/psychoactive medications and could place residents at risk of receiving unnecessary psychotropic medications.</p> <p>The findings included:</p> <p>Record review of Resident #11's face sheet dated 9/19/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: [Anxiety] a feeling of fear, dread, and uneasiness, [Hypertension], also known as high blood pressure, is a condition where the pressure in your blood vessels is too high. It's defined as a blood pressure of 140/90 or higher and [Hyperlipidemia] is a condition where there are high levels of lipids, or fats, in the blood.</p> <p>Record review of Resident #11's most recent comprehensive MDS assessment, dated 8/21/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and was treated with anti-anxiety medications.</p> <p>Record review of Resident #11's comprehensive care plan dated 8/14/24 revealed the resident had a diagnosis of anxiety and used antianxiety medication as ordered by the physician.</p> <p>Record review of Resident #11's Order Summary Report, dated 9/19/24 revealed the following:</p> <p>- Alprazolam Oral Tablet 0.25 MG (Alprazolam) Give 1 tablet by mouth every 24 hours as needed for anxiety disorder, with start date 8/12/24 and no stop date.</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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Medication Administration Record for August 2024 revealed the following:</p> <ul style="list-style-type: none"> - Alprazolam 0.25 mg was administered prn on 8/21/24. <p>During an observation and interview on 9/19/24 at 11:01 a.m., Resident #11 was observed in bed awake and alert. Resident #11 stated she needed the anxiety medication sometimes.</p> <p>On 9/19/24 at 12:02 p.m., during an interview, LVN A disclosed that she had previously given Alprazolam to Resident #11 to help with anxiety. LVN A explained that psychotropic medications like Alprazolam should be used for a limited time, usually up to 14 days. After 14 days, the nurse is required to contact the physician to reassess the resident's need for the medication. LVN A was unsure why the order for Alprazolam for Resident #11 was written for an indefinite period, and she expressed concern that the resident was at risk of falls by taking the medication for more than 14 days.</p> <p>During an interview and record review on 9/20/24 at 11:19 a.m., the Director of Nursing (DON) revealed that Resident #11 required the use of Alprazolam as recommended by the physician due to the resident's diagnosis. The DON stated that if the medication was taken all the time, it could result in Resident #11 being overmedicated. After reviewing Resident #11's order summary, the DON confirmed that there was no stop date on the order for prn Alprazolam. The DON revealed that the order for Alprazolam was possibly overlooked, as Resident #11 had transferred from assisted living to skilled nursing on 8/12/24, and a different set of regulations apply in skilled nursing. The DON stated that she was currently responsible for overseeing that psychotropic drugs are limited to 14 days, and her Assistant Director of Nursing (ADON) was to start monitoring this monthly moving forward to prevent this from occurring again.</p> <p>Record review of the facility policy and procedure titled, Policy and Procedure for Psychotropic medication use, dated 2001, updated July 2022, revealed in part, PRN orders for psychotropic medication are limited to 14 days.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44020</p> <p>Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 2 kitchens.</p> <p>The facility failed to ensure staff (the cook) covered their facial hair with a hair restraint in the main kitchen.</p> <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 09/18/2024 at 9:57 a.m. revealed the [NAME] in the main kitchen at the serving line placing uncovered sauces on the serving table while not wearing a beard restraint properly. The [NAME] was observed to have his facial hair restraint down around his neck. The [NAME] upon noticing the state surveyor placed his facial hair restraint over his mustache and beard.</p> <p>During an interview on 09/18/2024 at 10:04 a.m. with the [NAME] he stated staff were to use beard guards (facial hair restraints) so hair did not go into the food. The [NAME] further stated it prevents cross contamination. The [NAME] stated the beard guard (facial hair restraint) was to be worn when handling food or doing prep.</p> <p>During an interview on 09/19/2024 at 11:00 a.m. the Culinary Director stated the [NAME] was currently on a disciplinary action plan from August related to the [NAME] not wearing a facial hair restraint. The Culinary Director further stated due to the [NAME] not wearing his beard restraint properly on 09/18/2024 and having been written up regarding the issue previously a final disciplinary notice was issued. The Culinary Director stated the staff were to wear beard restraints (facial hair restraints) anytime they were handling and prepping food.</p> <p>During an interview on 09/20/2024 at 10:08 a.m. with the Culinary Director he stated hair restraints and facial hair restraints were to be worn to prevent hair from falling in the food or any other sort of contaminate that might be on the beard. The Culinary Director further stated hair falling into the food could cause food poisoning and many other issues.</p> <p>During an interview on 09/20/2024 at 10:16 a.m. the Dietician stated anytime staff were dealing with food items hair restraints should be used. The Dietician further stated hair and facial hair restraints were important in keeping hair out of the food during prep and service.</p> <p>Review of facility's policy Orientation and Education, Subject: Uniform Dress Code, revised date 01/2024, read Procedures: Associates Working with Food: Wear approved hair restraints when on duty regardless of length or presence of hair. The only exception is to remove hair restraints when delivering trays to patients/residents . Restrain all facial hair with a beard net/restraint.</p> <p>(continued on next page)</p>

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.		