

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/26/2024
NAME OF PROVIDER OR SUPPLIER Southpark Meadows Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 9801 S 1st Street Austin, TX 78748	
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 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for one (Resident #1) of four residents reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #1 was administered her prescribed Clonazepam (for anxiety), Duloxetine (for depression), Zyprexa (for agitation), and Melatonin (for insomnia) for four days after admission on 05/22/24. This caused her symptoms of confusion and agitation to exacerbate causing distress. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements or could result in worsening or exacerbation of chronic medical conditions. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including agitation, anxiety disorder, depression, stroke, and cognitive communication deficit. Review of Resident #1's EMR, on 05/26/24, reflected her 5-day MDS assessment had not been completed. Review of Resident #1's BIMS, dated 05/23/24, reflected a BIMS of 11, indicating a moderate cognitive impairment. Review of Resident #1's admission care plan, dated 05/22/24, reflected it had nothing related to her diagnoses or behaviors. Review of Resident #1's hospital records, dated 05/18/24, reflected the following: Called by RN as [Resident #1] was throwing food, water, meds . security called . Zyprexa 2.5 mg IV ordered . AMS/Agitation . Zyprexa BID, E sitter ordered . Review of Resident #1's hospital records, dated 05/19/24, reflected the following: (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676299	Facility ID: 676299 If continuation sheet Page 1 of 3

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F 0755 Level of Harm - Actual harm Residents Affected - Some	[Resident #1] with waxing/waning MS . change Zyprexa to 2.5 mg PO Q6 hours PRN . has E sitter (cannot go to SNF with E sitter) . Disposition - to SNF once MS improved . Review of Resident #1's hospital records, dated 05/20/24, reflected the following: Remove sitter at 3 PM if [Resident #1] is oriented and alert . PT/OT - resume therapy today . Review of Resident #1's hospital records, dated 05/21/24, reflected the following: Stop sitter at 3 PM today . less confused . Anticipate SNF discharge tomorrow afternoon. Review of Resident #1's discharge medications in her hospital records, dated 05/22/24, reflected the following: Clonazepam - 0.5 mg - po BID Duloxetine - 20 mg - po BID Zyprexa - 2.5 mg - po qhs Melatonin - 10mg - po qhs Review of Resident #1's MAR, May of 2024 on 05/26/24, reflected she received her first dose of Clonazepam and Duloxetine on the morning of 05/26/24. She had not received any doses of Melatonin or Zyprexa since she was admitted on [DATE]. From 05/23/24 - 05/25/24, LVN D marked 9, which was defined as Other/See Progress Notes. Review of Resident #1's progress notes, from 05/23/24 - 05/25/24, reflected no progress notes documented by LVN D related to medications. Review of Resident #1's progress notes in her EMR, dated 05/25/24 at 6:27 PM and documented by RN A, reflected the following: Day shift nurse reports [Resident #1] refused all three meals today but did accept a health shake. Review of Resident #1's progress notes in her EMR, dated 05/25/24 at 7:22 PM and documented by RN A, reflected the following: . [Resident #1] began using racial slurs, throwing items in her room . Review of Resident #1's progress notes in her EMR, dated 05/26/24 at 4:30 AM and documented by RN A, reflected the following: Staff reports that [Resident #1] was cursing and shoving furniture in her room and throwing items. Review of Resident #1's progress notes in her EMR, dated 05/26/24 at 5:31 AM and documented by RN A, reflected the following: (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Some	[Resident #1] near the nurse's station uses her cell phone to call (city) police department. Reports someone stole her phone charger and she believes she is being mistreated. During an observation and interview on 05/26/24 at 9:47 AM revealed Resident #1 ambulating with her walker slowly around the nurses' station. She was agitated and distressed and stated she had not slept in two days and she had no idea what was going on. She repeatedly laid her head on the desk of the nurses' station, moaning that she was so tired. LVN B redirected Resident #1 towards her room and stated they had been waiting on some of her medications to arrive and she had gone without several medications and that was why she had been anxious, agitated, and not sleeping well. During an interview on 05/26/24 at 10:40 AM, RN A stated Resident #1 had not slept last night and was more agitated than usual. She stated she was throwing furniture and yelling at staff. She stated she had not worked in a few days and it looked like her medications were still pending delivery from the pharmacy but she utilized the e-kit for her morning medications. She stated she had already called the pharmacy to try and get an update. During an interview on 05/26/24 at 10:47 AM, CNA C stated Resident #1 had been more confused and agitated since she was admitted . She stated she was restless and anxious all night and did not sleep. During an interview on 05/26/24 at 11:11 AM, the ADON stated the nurse management team was responsible for ensuring medications were in house and readily available upon residents' admission. He stated if there were not medications available for a resident, he would it was the nurse's responsibility to contact the DON and NP or call the pharmacy for a stat delivery. He stated their pharmacy makes deliveries twice a day and it would be unacceptable for any resident to go multiple days without their scheduled medications. He stated if a resident went days without medications such as Duloxetine, Zyprexa, and Clonazepam, it could cause increased anxiety and could affect all aspects of their mental health. He stated he was not aware Resident #1 had gone multiple days without these medications. He stated he was not sure if those particular medications (Duloxetine, Clonazepam, Zyprexa, and Melatonin) were in their emergency medication kit. On 05/26/24 multiple telephone calls were made to LVN D. A returned phone call was not received prior to exiting. Review of the facility's Medication Orders Policy, revised 10/01/19, reflected the following: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by the licensed nurses or pharmacists and confirmed in writing by the prescriber within 48 hours. . C. Emergency Medication Order: (Medication NOT contained in emergency medication supply) An emergency order is placed with the provider pharmacy, and the medication is scheduled to be given as negotiated with the pharmacy and based on logistics and applicable regulations. Stat orders always require direct communication between a nurse and a pharmacist to adequately assess the situation and define a resolution.		