

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 06/06/2025
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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) of five residents reviewed for care plans, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to care plan for Resident #1's 05/11/25 orthopedic ordered left arm sling prescribed for comfort, no discontinue date. 2 The facility failed to care plan Resident #1's history of refusal of care and medication from 12/07/2024 and 05/09/25. <p>This failure placed residents at risk of not receiving the benefit of prescribed orthopedic equipment, risk of pain and discomfort and a lack of goals and interventions for the residents' individual needs for person-centered care.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 06/06/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body), cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (a type of stroke caused by reduced or blocked blood flow to the brain), and other cerebral infarction due to occlusion or stenosis of small artery (ischemic strokes, caused by the blockage or narrowing of smaller arteries within the brain).</p> <p>Review of Resident #1's quarterly MDS assessment, dated 05/12/25, reflected a BIMS score of 13, indicating no cognitive impairment. Section GG (Functional Abilities) reflected he was impaired on one side of both upper and lower extremities.</p> <p>Review of Resident #1's care plan reflected no identified problems, goals, or interventions for his prescribed left arm sling or his history of refusal of care and medication.</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 12/07/2024 reflected, notified by CNA staff was in room to adjust pt in bed and to be check and change if needed pt refuse c/not [sic] right now maybe later</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 12/08/2024 reflected, Enoxaparin Sodium Injection Solution Prefilled Syringe (prefilled syringe is a medication used to prevent and treat blood clots) 30 MG/0.3ML Inject 1 dose subcutaneously (under the skin) every 12 hours for anticoagulant (medications that prevent blood clots from forming) [Resident #1] refuse c/o too much medication has been given and will make him sick</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 01/05/25 reflected, give 12 grams by mouth two times a day constipation Mix with 4-8 oz of liquid resident refuse</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 01/21/25 reflected Np on call notified resident refuse 10 units of Lantus (insulin) this am</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 03/28/25 reflected, resident refuse dinner wife @ bedside alternate taken to room (steak fingers) refuse yelling @ nurse, 'I don't want that'</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 04/10/25 reflected pain medication was offered to Resident #1 and he stated, I don't want noting. I don't want anything from you. i don't want anything from anybody I'm fine.</p> <p>Record review on 06/06/25 of Nurses Progress Note by LVN A dated 05/09/25 reflected Resident #1 refusal for staff to assist pt back in bed.</p> <p>Record review on 06/06/25 of Nurses Note by the DON dated 05/09/25 reflected, Apply left arm sling for comfort as tolerated. one time a day for Left arm healing</p> <p>Record review on 06/06/25 of Resident #1's order dated 05/11/25, entered by the DO reflected Apply left arm sling for comfort as tolerated. one time a day for Left arm healing.</p> <p>Record review on 06/06/15 of Nurses Note by LVN A dated 05/25/25 reflected, Apply left arm sling for comfort as tolerated. one time a day for Left arm healing.</p> <p>Interview on 06/06/25 at 12:24 pm with Resident #1 reflected he had a sling for his left arm, but they did not put it on him. He said they used to, but they did not put it on him anymore he said his left arm hurt a lot.</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 06/06/25 at 4:05 with LVN B reflected she put Resident #1's left arm sling on him daily if he wanted her to. She said, at times, he would agree to wear it, and the next time she entered his room, he would have removed it. She said he was, not a very big fan for it. She said that he had two or three left arm slings, and there is one he liked better than the other. She said the one he liked was blue and soft and in the neck area there was some padding, and that was the one he would be more compliant to wear. She said there had been times when Resident #1 had refused to wear the left arm sling. She said he would say, maybe later or that thing just does not work. She said she attended facility daily staff morning meetings, and they discussed Resident #1 and his left arm sling. She said Resident #1's left arm sling was discussed more when it was first introduced and not very much after, maybe because he was not wearing it as much. LVN B said the care plan contained the interventions for the residents to be at their best functioning. She said she did not look at care plans every day, but she found them helpful. She said that if a resident had an order for equipment, it should be included in the care plan. She said she did not think Resident #1's left arm sling was helping him, and because it was not helping him, it did not need to be included in the care plan. She said the social worker, the MDS Coordinator and the DON were responsible for the care plans. She said care plans were not the responsibility of the floor nurses. She said that resident noncompliance should be included in the care plan and Resident #1's noncompliance with his left arm sling should have been included in the care plan. She said, in the past, Resident #1 had refused to take his medications and had a history to telling the staff No to care.</p> <p>Interview on 06/06/25 at 3:10 pm with LVN/MDSC revealed she was responsible for care plans and the updating of care plans, and stated that resident diagnoses, resident behaviors, and resident orthotics should be care planned. She said she was not a floor nurse, but she got information for care planning during the facility daily staff morning meetings. She said floor nurses would provide updates regarding behaviors from the previous day that needed to be added to the care plan. She said she relied on the floor nurses, the nurse manager, the DON, and the ADONs to help with the information to update care plans. She said a care plan was a tool used to determine a problem and it has a set of goals and interventions for the resident needs. She said the floor staff knew best know how to care for a resident. She said a care plan was necessary because it let the team know what the residents' needs were. She said if someone had a sling, it should be included in the care plan. She said the possible negative outcome, if care plans were not updated, was that certain care might not be provided to the resident, or the nurses might not know how to manage a problem. She said Resident #1's refusal to wear the sling should definitely be care planned. She said the sling was prescribed for comfort and to hopefully minimize some of Resident #1's pain.</p> <p>Interview on 06/06/25 at 4:52 pm with the Administrator reflected a care plan was the comprehensive tool used to direct specific resident centered care. He stated the MDS nurses are responsible for the care plans. He said the MDS Coordinators were not floor nurses, and they received the information to updated residents' care plans from information received from resident care reports facility daily staff morning meetings, and talking to the floor nurses. The Administrator revealed that Resident #1's left arm sling should have been included in the care plan. He said it was the responsibility of the MDS Coordinators to make sure residents have everything in the care plan. It was the responsibility of the DON or the regional care management specialist to make sure the care plan was accurate. The negative effects of not having a complete care plan were that the resident could receive inadequate care.</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 06/06/25 at 1:29 pm with the DON reflected Resident #1 had a specific sling that he liked to use when he allowed staff to put his left arm sling on for him. The DON said that more than 50% of the time, Resident #1 did not allow staff to put the sling on Resident #1. The DON said that during the facility daily morning staff meetings, it had been discussed that Resident #1 either refused to wear the left arm sling or removed the left arm sling, and it ended up on the floor. The DON stated that Resident #1's prescribed arm sling should be care planned. The possible outcome of Resident #1 not wearing his sling was discomfort and improper healing. She stated that it was upsetting and bothersome that Resident #1's left arm sling is not care planned, and that his refusal to wear his sling was not care planned. The DON said the importance of a care plan was that it set forth the care for the resident that included a resident's medical and behavioral orders how orders should be followed. She stated that if Resident #1 choses the use of one specific left arm sling over another left arm sling, this information should have been in the care plan. The DON said Resident #1 preferred the sling that had the pad on the strap towards the back, but that was not the sling that was in his room. She said the care plan was the responsibility of the MDS Coordinator, and the MDS Coordinator was not a floor nurse but Resident #1's non-compliance with his sling usage was discussed in the facility morning meetings when the MDS coordinator was present. The DON said Resident #1's other non-compliant behaviors were discussed in the facility morning meetings when the MDS Coordinator was present. She said she believed Resident #1's non-compliance with his left arm sling was discussed about 3 times during morning meeting, and his other non-compliance behaviors were discussed pretty frequent. She said it was the responsibility of the DON to follow up and make sure resident care plans were complete with information that was discussed during morning meetings. The DON said that if a care plan was not updated, resident care could be neglected and not carried out for both the resident's mental and physical needs.</p> <p>Interview on 06/06/25 at 3:51 pm with the NP revealed Resident #1 had an old fracture to his left elbow and the issue with his left arm sling was Resident #1's lack of compliance. She said the nurses would put the sling on him and Resident #1 would remove it and shove it in a drawer. She said that he had told her that no one was giving him his left arm sling to wear. She said the order for the left arm sling was given to Resident #1 by the by the orthopedic doctor for comfort.</p> <p>Review of the facility's policy, Comprehensive Care Plans dated 10/24/22, reflected it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Person centered means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. The comprehensive care plan will include measurable objectives and time frames to meet the residents needs as identified in the residents' comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed.</p>		