STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676299	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpark Meadows Nursing and Rehabilitation Cente	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the required documentation in the resident's medical record made by the physician for a safe and effective transition of care 1 (Resident #1) of 5 residents reviewed for transfer or discharge. The facility discharged Resident #1 on 06/03/26 without physician documentation in the EMR. This failure could place residents at risk for inappropriate discharge resulting in psychological harm due to feelings of anger and sadness.Findings included: Record review of Resident #1's face sheet, dated 06/19/26, reflected a [AGE] year-old male, admitted [DATE], with diagnosis that included unspecified dementia- unspecified severity-without behavioral disturbance- psychotic disturbance- mood disturbance and anxiety (group of symptoms affecting memory, thinking, and social abilities), cognitive communication deficit, cerebral palsy (group of conditions that affect movement and posture caused by brain damage before birth), unspecified intellectual disabilities, and schizophrenia (serious mental health condition affecting how people think, feel, and behave). The face sheet reflected Resident #1 was discharged [DATE] to other nursing home/SNF. Record review of Resident #1's Discharge Return Not Anticipated MDS assessment, dated 06/03/26, reflected a discharge date of 06/03/26. Cognitive patterns reflected a BIMS score of 0, indicating severe cognitive impairment, and the resident was rarely/never understood. Active diagnosis reflected schizophrenia (serious mental health condition affecting how people think, feel, and behave) and dementia (group of symptoms affecting memory, thinking, and social abilities). Record review of Resident #1's care plan, reflected a focus initiated on 05/26/26 , Resident #1 has been identified as having PASRR positive status related to ID due to cerebral palsy and intellectual debility. with interventions that included .coordinate services with a representative from the local authority. Another focus initiated on 05/24/26 included, Resident #1 has behavior problem. He was noted to have inappropriately touched a female resident r/t poor impulse control d/t intellectual disability. with interventions that included .1:1 monitoring by staff member, intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause. The care plan indicated on a focus initiated 11/21/25 Resident #1 had impaired cognitive function or impaired thought process related to schizophrenia and was being seen by psychiatric services. Record review of Resident #1's progress notes reflected the following:SW note, dated 05/24/26 at 12:38 PM, indicated, attempted to talk to Resident #1 regarding alleged incident that occurred earlier. Resident was found sitting with his 1:1. Resident won't answer any questions or maintain eye contact, just keeps looking away when asked questions. Resident is developmentally delayed and this is not uncommon behavior for him. also notified psychiatry of alleged incident.A nursing note, dated 5/24/26 at 01:00 PM, indicated, aggressor: staff member reported seeing this resident touch a female resident both breasts, staff member states she called out for him to stop, resident immediately stopped, she called out for another staff member, aide, and nurse. Residents separated immediately, administrator notified, [city police] called, reported to HHSC, 1:1 monitoring initiated immediately, notifications to RP/NP.A nursing note, dated 6/3/26 at 10:50 AM, indicated, (continued on next page)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transportation arrived from [receiving SNF] medications and belongings taken. Pt noted pleasant, no s/s of distress noted. Record review of Resident #1's psychiatric provider assessment note, dated 06/01/26 by PMHNP, reflected: Pt with PMH dementia insomnia and schizophrenia. Pt seen for medication management and inappropriate behavior. Nursing reported he groped another resident. On exam, he is seen in room, with obvious aphasia and cognitive deficits. Chart and MAR reviewed, pt with intellectual disabilities. Nursing reports intermittent behaviors, but no other inappropriate behaviors or increase in elopement attempts. Pt unable to recall events, likely due to impulsiveness and not malicious behaviors. Record review of a FRI, received 5/24/26 (with follow up provider investigation attached 6/2/26), reflected the following documentation:Incident date of 5/24/26: Incident reported to ADM r/t Resident #1 found touching another resident on her breast over her clothes. Residents were separated and assessed, no injuries noted, Resident #1 was placed on 1:1 monitoring.Eight resident safe surveys, dated 05/24/26 conducted by the SW, reflected that they denied anyone touching them inappropriately.Eleven staff members' written statements, all dated 05/26/26, indicated they had not seen any previous history of Resident #1 touching other residents inappropriately.In a report by the ADM, signed 5/29/26, after the incident indicated: Officers visited but the residents did not recall the event and no distress observed from either resident. Review of the care plans had not shown any history of those behaviors. Neither residents have had any previous similar interactions with each other nor other residents since the date of both of their admissions. Record review of Resident #1's EMR, accessed 06/19/26 reflected there was no documentation by Resident #1's physician documenting the basis for the transfer or the danger that the failure to transfer or discharge the resident would pose and if failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. During an interview on 06/19/26 at 10:42 A.M., Resident #1's family member stated she was alerted by the facility of the incident that occurred Sunday 5/24/26 and that she was told they immediately wanted to get rid of him by Monday 5/25/26. She stated the first few facilities the current SNF tried to move him to denied him, then he was accepted into an all-male facility and officially d/c on 6/3/26. She stated she was not provided with options of where to place the resident, she was not given a formal written notice with information to the ombudsman, the LIDDA (resident was PASRR positive) or information on appeal rights. She stated this was not a behavior the resident had ever had before, and that her biggest issue was the rush the facility placed on displacing him. She stated she did not speak to the provider or was provided with documentation indicating the basis of the discharge. During an interview on 06/19/26 at 12:31 P.M. the SW stated she did not issue the d/c notices that they were completed by the ADM. She stated that a 30-day notice was typically required unless a resident presented a risk of harm to other residents or the facility. She stated in those cases the incident would need to be documented, the history of behaviors by the provider (MD or NP) that sees the resident. She stated the reason for Resident #1's discharge was the incident that occurred on 05/24/26 with him touching another resident inappropriately. She stated he did not have similar behaviors or a history of these behaviors at the facility. She stated Resident #1 or his RP were not provided a written discharge notice. She stated she did not see documentation in the resident's chart made by a physician with the basis of the discharge and need for emergency discharge and the danger the failure to transfer or discharge would pose. During an interview on 06/19/26 at 01:07 PM, the DON stated the facility's SW and ADM were responsible for discharges. She stated if there were negative behaviors the facility got with psychiatric services to make a determination if they needed to discharge a resident. She stated if a resident was discharged by the facility, it could be a 30-day notice or less, if the resident presented with negative behaviors. She stated the reason for Resident #1's discharge was he was groping one of the females. She stated he was immediately placed on 1:1 and did not have a history of these behaviors. She stated he was not able to be interviewed about the events due to his cognition and diagnosis. She stated she could not find documentation in the chart from a physician detailing the safety concerns or provider notes indicating the behavior that warranted the discharge. She stated, (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on the policy and regulation, the discharge process was not followed. During an interview on 06/19/26 at 01:40 PM with the ADM, he stated the reason for discharge of Resident #1 was the behavior he had on 05/24/26 r/t inappropriate behavior with another resident. He stated Resident #1 did not have a history of those behaviors. He stated Resident #1 was not intervieable due to his cognition and diagnosis, he could not complete sentences. The ADM stated he handles the final discharges of residents. He stated he was unsure of there being any provider notes indicating the basis of the discharge. Record review of the facility policy titled, Transfer and Discharge (including AMA), dated 3/5/25 reflected: Policy:It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.Policy Explanation and Compliance Guidelines:The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs.Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.The facility will obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis.If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 5 residents reviewed for discharge planning. The facility failed to notify Resident #1 and Resident #1's RP of Resident #1's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understand, and at least 30 days before Resident #1 was discharged from the facility on 06/03/26 in a facility-initiated discharge to another skilled nursing facility.The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #1 was discharged from the facility on 06/03/26 and failed to notify the LIDDA (Resident #1 was PASRR positive). This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services.Findings included: Record review of Resident #1's face sheet, dated 06/19/26, reflected a [AGE] year-old male, admitted [DATE], with diagnosis that included unspecified dementia- unspecified severity-without behavioral disturbance- psychotic disturbance- mood disturbance and anxiety (group of symptoms affecting memory, thinking, and social abilities), cognitive communication deficit, cerebral palsy (group of conditions that affect movement and posture caused by brain damage before birth), unspecified intellectual disabilities, and schizophrenia (serious mental health condition affecting how people think, feel, and behave). The face sheet reflected Resident #1 was discharged [DATE] to other nursing home/SNF. Record review of Resident #1's discharge return not anticipated MDS assessment dated [DATE] reflected a discharge date of 06/03/26. Cognitive patterns reflected a BIMS score of 0 resident is rarely/never understood indicating severe cognitive impairment. Active diagnosis reflected schizophrenia and dementia. Record review of Resident #1's care plan revised 06/17/26 reflected a focus of Resident #1 has been identified as having PASRR positive status related ID due to cerebral palsy and intellectual debility with interventions that included coordinate services with a representative from the local authority. Another focus included Resident #1 has behavior problem. He was noted to have inappropriately touched a female resident r/t poor impulse control d/t intellectual disability with interventions that included 1:1 monitoring by staff member, intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause. The care plan indicated resident had impaired cognitive function or impaired thought process related to schizophrenia and was being seen by psychiatric services. Record review of Resident #1's progress notes reflected the following:SW note, dated 05/24/26 at 12:38 PM, indicated, attempted to talk to Resident #1 regarding alleged incident that occurred earlier. Resident was found sitting with his 1:1. Resident won't answer any questions or maintain eye contact, just keeps looking away when asked questions. Resident is developmentally delayed and this is not uncommon behavior for him. also notified psychiatry of alleged incident.A nursing note, dated 5/24/26 at 01:00 PM, indicated, aggressor: staff member reported seeing this resident touch a female resident both breasts, staff member states she called out for him to stop, resident immediately stopped, she called out for another staff member, aide, and nurse. Residents separated immediately, administrator notified, [city police] called, reported to HHSC, 1:1 monitoring initiated immediately, notifications to RP/NP.A nursing note, dated 6/3/26 at 10:50 AM, indicated, transportation arrived from [receiving SNF] medications and belongings taken. Pt noted pleasant, no s/s of distress noted. Record review of Resident #1's psychiatric provider assessment note dated 06/01/26 by PMHNP reflected: Pt with PMH dementia insomnia and schizophrenia. Pt seen for medication management and inappropriate behavior. Nursing reported he (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	groped another resident. On exam, he is seen in room, with obvious aphasia and cognitive deficits. Chart and Mar reviewed, pt with intellectual disabilities. Nursing reports intermittent behaviors, but no other inappropriate behaviors or increase in elopement attempts. Pt unable to recall events, likely due to impulsiveness and not malicious behaviors. Record review of a FRI received 5/24/26 (with follow up provider investigation attached 6/2/26) reflected the following documentation:Incident date of 5/24/26: Incident reported to ADM r/t Resident #1 found touching another resident on her breast over her clothes. Residents were separated and assessed, no injuries noted, Resident #1 was placed on 1:1 monitoring.8 resident safe surveys were reviewed dated 05/24/26 conducted by the SW and reflected they denied anyone touching them inappropriately.11 staff members written statements all dated 05/26/26 indicated they had not seen any previous history of Resident #1 touching other residents inappropriately.In a report by the ADM signed 5/29/26 it reflected after the incident: Officers visited but the residents did not recall the event and no distress observed from either resident. Review of the care plans had not shown any history of those behaviors. Neither residents have had any previous similar interactions with each other nor other residents since the date of both of their admissions. Review of Resident #1's EMR accessed on 06/19/26 reflected there was no documentation by Resident #1's physician documenting the basis for the transfer or the danger that the failure to transfer or discharge the resident would pose if failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. There was no record of a discharge notice to the resident in writing, contact to the state long term care ombudsman or the LIDDA. During an interview on 06/19/26 at 10:42 AM with Resident #1's family member, she stated she was alerted by the facility of the incident that occurred Sunday 5/24/26 and that she was told they immediately wanted to get rid of him by Monday 5/25/26. She stated the first few facilities the current SNF tried to move him to denied him, then he was accepted into an all-male facility and officially d/c on 6/3/26. She stated she was not provided with options of where to place the resident, she was not given a formal written notice with information to the ombudsman, the LIDDA (resident was PASRR positive) or information on appeal rights. She stated this was not a behavior the resident had ever had before, and that her biggest issue was the rush the facility placed on displacing him. She stated she did not speak to the provider or was provided with documentation indicating the basis of the discharge. During an interview on 06/19/26 at 12:31 PM with the SW she stated she did not issue the d/c notices that they were completed by the ADM. She stated that a 30-day notice is typically required unless a resident presents a risk of harm to other residents or the facility. She stated in those cases the incident would need to be documented, the history of behaviors by the provider that sees the resident. She stated the reason for Resident #1's discharge was the incident that occurred on 05/24/26 with him touching another resident inappropriately. She stated he did not have similar behaviors or a history of these behaviors at the facility. She stated Resident #1 or his RP were not provided with a written discharge notice. She stated she did not see documentation in the residents' chart made by a physician with the basis of the discharge and need for emergency discharge and the danger the failure to transfer or discharge would pose. The SW stated notification of the d/c needs to be made to the MD or NP, the patient and their RP. She stated, you probably should notify the ombudsman. She stated the LIDDA would also need to be notified if the resident is PASRR positive. She stated the purpose of notifying the ombudsman is to ensure the residents' rights are being followed and PASRR residents need the LIDAA notified to ensure they are sending the resident to an appropriate facility. She stated the notifications needed to be made before the discharge. She stated a negative outcome of not making the notifications would be residents had the potential to be discharged to an inappropriate facility. The SW stated Resident #1 was not issued a written 30-day notice with the information to the ombudsman or the LIDDA, or his right to appeal. She stated she did not personally contact the ombudsman or LIDDA and believed the ADM would be the one to do that. During an interview on 06/19/26 at 01:07 PM with the DON she stated the facility SW and ADM are responsible for discharges. She stated if there were negative behaviors the facility gets with (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatric services to make a determination if they need to discharge a resident. She stated if a resident is discharged by the facility, it can be 30-day notice or less if the resident presents with negative behaviors. She stated the reason for Resident #1's discharge was he was groping one of the females. She stated he was immediately placed on 1:1, he did not have a history of these behaviors. She stated he was not able to be interviewed about the events due to his cognition and diagnosis. She stated she could not find documentation in the chart from a physician detailing the safety concerns or provider notes indicating the behavior that warranted the discharge. She stated, based on the policy and regulation, the discharge process was not followed. The DON stated parties that needed to be notified of a d/c included the MD, the resident or resident RP, if they were PASRR positive the LIDDA would need to be notified as well. The DON stated the Ombudsman needed to be notified of all discharges but doesn't know why. She stated if those parties were not notified it could negatively affect the services the residents were to receive. The DON stated she could not find any documentation indicating the LIDDA or Ombudsman were notified. During an interview on 06/19/26 at 01:40 PM with the ADM, he stated the reason for discharge of Resident #1 was the behavior he had on 05/24/26 r/t inappropriate behavior with another resident. He stated Resident #1 did not have a history of those behaviors. He stated Resident #1 was not interviewable due to his cognition and diagnosis, he could not complete sentences. The ADM stated he handles the final discharges of residents. He stated he was unsure of there being any provider notes indicating the basis of the discharge. The ADM stated that for Resident #1's d/c the ombudsman was not notified, he stated that if a resident was on PASRR that they would need to be included in the process, denied the LIDDA being contacted. He stated the purpose of notifying the ombudsman was they are an advocate for the residents and help them address any discharge concerns they have, he stated notifying the LIDDA would ensure continuity of services. He stated failing to notify the ombudsman or LIDDA of a resident discharge would be the advocacy component is not there, and the continuation of services would not be there. He stated there was no documentation of them being notified. Record review of the facility Transfer and Discharge (including AMA) policy dated 3/5/25 reflected: Policy:It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.Policy Explanation and Compliance Guidelines:The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs.Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: The specific reason and basis for transfer or discharge.The effective date of transfer or discharge.The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .An explanation of the right to appeal the transfer or discharge to the State.The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.Information on how to obtain an appeal form.Information on obtaining assistance in completing and submitting the appeal hearing request.The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations.Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:The health and/or safety of individuals in the facility would be endangered due to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the clinical or behavioral status of the resident;In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.The facility will maintain evidence that the notice was sent to the Ombudsman.The facility will obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis.If the resident chooses to appeal the discharge, the facility will allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.