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	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpark Meadows Nursing and Rehabilitation Cente	9801 S 1st Street Austin, TX 78748

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 4 of 7 residents (Resident #59, Resident #23, Resident #46, and Resident #29) reviewed for infection control. 1. The facility failed to properly use personal protective equipment during wound care for Resident #23.2. The facility failed to follow hand hygiene procedure during direct care for Resident #59, Resident #46, and Resident #29.This failure could place residents at risk for infection transmission, sepsis, and hospitalization. Findings included:Observation on 10/01/2025 at 9:59 AM revealed LVN B did not remove personal protective equipment (gown) after she removed contaminated wound dressing, cleaned the wound and forgot the Topical Antibiotic Ointment on her treatment cart outside of Resident's #23's room. She removed gloves, sanitized her hands, but did not remove the gown. LVN B exited Resident #23's room, opened the treatment cart, removed medication and came back to Resident #23's room wearing the same gown. Record review of Resident #23's face sheet, dated 10/03/2025, revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included idiopathic gout (a form of inflammatory arthritis (conditions that cause inflammation and damage to the joints)) caused by the accumulation of uric acid crystals in the joints), chronic kidney disease (condition in which the kidneys gradually lose their ability to filter waste products from the blood, leading to damage and dysfunction), venous thrombosis (a condition where a blood clot forms in a vein, typically in the deep veins of the legs or arms) and embolism (a medical condition where a foreign object or clot travels through the bloodstream and blocks a blood vessel). Record review of Resident #23's Annual MDS assessment, dated 09/21/2025, with BIMS score 15 indicated the Resident #23 had intact cognitive functions. Record review of Resident #23's orders dated 09/16/2025, indicated wound care order to left calf venous ulcer clean area with wound cleanser, pat dry, apply topical antibiotic to wound bed, cover with dry dressing two times a day every other day for wound care and as needed for if soiled or dislodged following enhanced barrier precautions.Interview on 10/01/2025 at 10:15AM of LVN B revealed she was trained on hand hygiene and infection control policy. This training included the proper application and removal of personal protective equipment (PPE) before and after existing the room of residents. LVN B was certified as an infection preventionist and wound care nurse at the facility. LVN B stated she completed in-service training in following enhanced barrier precautions last month. She stated that following proper infection control procedures protects residents and staff from getting sick and prevents the spread of infection. LVN B stated she forgot to remove the PPE gown when exited resident's room due to being too nervous while observed by state surveyor.Observation on 10/01/25 at 11:15 AM revealed LVN A performed blood sugar check for Resident #46. He did not change gloves after completing blood sugar check and touched the doorknob to open the door and nursing cart when exited Resident #46's room. Record review of Resident #46's face sheet, dated 10/03/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage) affecting left (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-dominant side, type 2 diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).Record review of Resident #46's Quarterly MDS assessment, dated 08/21/2025, with BIMS score 10 indicated moderate cognitive impairment.Record review of Resident #46's Care Plan, dated 10/10/24, reflected thatResident #46 had diagnosis of Diabetes Mellitus and risk for hyper/hypoglycemia.An interview of LVN A on 10/01/25 at 11:21 AM, revealed he was trained in hand hygiene and infection control policy. LVN A stated he was supposed to take gloves off after completing direct patient care including blood sugar check procedure. He stated that not removing contaminated gloves could cause cross contamination and spread infection to other residents. Record review of Resident #46's face sheet, dated 10/03/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage) affecting left non-dominant side, type 2 diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).Record review of Resident #46's Quarterly MDS assessment, dated 08/21/2025, with BIMS score 10 indicated moderate cognitive impairment.Record review of Resident #46's Care Plan, dated 10/10/24, reflected thatResident #46 had diagnosis of Diabetes Mellitus and risk for hyper/hypoglycemia.Observation on 10/01/2025 at 12:31 PM of CNA A performed peri-care for Resident #29. CNA A did not remove contaminated gloves after performing peri-care and cleaning urinary catheter. She pulled Resident's #29's clothes and transferred resident to the wheelchair without removing the gloves. Interview on 09/24/25 at 12:51 PM with CNA A revealed she had hand hygiene and peri-care training provided monthly. CNA A stated she forgot to remove gloves after completing Resident #29's peri care. CNA A stated not removing contaminated gloves she could make residents sick.Record review of Resident #29's face sheet, dated 10/03/2025, revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included sepsis with an unspecified organism (a systemic infection where the specific organism causing the infection is unknown), macular degeneration (eye disease that affects the macula, the central part of the retina responsible for sharp, central vision), type 2 diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and dementia (a general term for a group of conditions that cause a decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life).Record review of Resident #29's admission MDS assessment, dated 09/15/25, with BIMS score 14 indicated intact cognitive functions.Record review of Resident #29's Care Plan, dated 09/25/2025, reflected thatResident #29 had Self Care Performance Deficit and indwelling catheter in place.Observation on 10/03/2025 at 8:38 AM revealed CNA B performed peri-care for Resident #59. CNA B did not remove contaminated gloves between providing peri care of front and back peri area. CNA touched and removed wipes from the package with contaminated gloves. An interview on 10/03/2025 at 8:55 AM, revealed CNA B had infection control and hand hygiene training a week ago. She stated that she was trained in removing gloves between dirty and clean areas to prevent spreading infection to residents. She stated that she forgot to do it while performing direct care to Resident #59.Record review of Resident #59's face sheet, dated 10/03/2025, revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, the trunk, and often the face), dementia (a general term for a group of conditions that cause a decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life), and gastroparesis (a condition where the stomach empties food into the small intestine too slowly).Record review of Resident #59's Quarterly MDS assessment dated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] revealed a BIMS Score of 2, which reflected severe cognitive impairment. Record review of Resident #59's Care Plan dated 06/11/2025 reflected:Resident #59 had self-care performance deficit and risk for impaired skin integrity due to bladder and bowel incontinence. In interview on 10/03/2025 at 3:40 PM DON stated DON, infection preventionist nurse and charge nurses were responsible for ensuring staff were conducting proper hand hygiene/following infection control measures when providing care for the residents. She stated she conducts weekly routine checks and in-services. She stated the policy on hand hygiene, providing peri-care, wound care, and foley catheter care was to conduct hand hygiene before going in the room, between changing gloves and front/back peri-cares and when coming out of the room. The DON stated the last training on infection control and hand hygiene was conducted last month and during annual skills training sessions, weekly audits, and in huddles. The DON stated a potential negative outcome for the residents would be the cross contamination.Interview on 10/03/2025 at 3:35PM with the ADM, who stated that hand hygiene and wearing/changing gloves is one of most important requirements for staff in this facility to prevent risk of infection. He stated that nursing staff, including himself, received in-services on hand hygiene policy. Review of Infection Control Policy, dated 10/24/2022, reflected: The fundamental of infection control precautions is hand hygiene before and after direct resident contact, before and after assisting a resident with personal care, before and after changing a dressing, after removing gloves, after handling soiled equipment. Record review of Hand Hygiene Policy dated 10/24/2022 indicated that All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.Record review of Perineal Care policy dated 10/4/2022 indicated in (10) re-position resident, change gloves if soiled and continue with perineal care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 4 residents (Resident #45, and Resident #105) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #45's admission MDS, dated [DATE], accurately reflected his smoking status. 2. The facility failed to ensure Resident #105's annual MDS, dated [DATE], accurately reflected his smoking status.These failures could place residents at risk of inadequate supervision due to an inaccurate assessment of smoking status. Findings Included:1. Record review of Resident #45's dated 10/03/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had a diagnosis which included lack of coordination, muscle wasting, attention and concentration deficit (ongoing problems with focus, organization, and impulsiveness), cognitive communication deficit (problems with communication), pulmonary embolism without acute cor pulmonale (blood clot in the lungs without difficulty breathing) and hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke).Record review of Resident #45's admission MDS dated [DATE] revealed Resident #45 had a BIMS of 12 which indicated moderate impairment. The MDS also revealed current tobacco use was marked as no.Record review of Resident #45's care plan dated 09/21/2025, revealed Resident #45 was a smoker. The goals in place were that the resident would not smoke without supervision through the review date. The resident would not suffer injury from unsafe smoking practices through the review date. Interventions were instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Observe clothing and skin for signs of cigarette burns. The resident requires SUPERVISION while smoking.Record review of Resident #45's Smoking Safety Screen dated 10/02/2025, revealed Resident #45 had dexterity (skill in performing tasks, especially with the hands). The smoking safety screen also stated the resident was to be supervised while smoking. 2. Record review of Resident #105's dated 10/03/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #105 had a diagnosis which included lack of coordination, muscle wasting, altered mental state, personal history of traumatic brain injury (usually a violent blow to the head), cognitive communication deficit (problems with communication), seizures, and repeated falls.Record review of Resident #105's annual MDS dated [DATE] revealed Resident #105 had a BIMS of 11 which indicated moderate impairment. The MDS also revealed current tobacco use was marked as no.Record review of Resident #105's care plan dated 09/21/2025, revealed Resident #105 was a smoker. The goals in place were that the resident would not smoke without supervision through the review date. The resident would not suffer injury from unsafe smoking practices through the review date. Interventions were instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Observe clothing and skin for signs of cigarette burns. The resident requires SUPERVISION while smoking.Record review of Resident #105's Smoking Safety Screen dated 10/02/2025, revealed Resident #105 was to be supervised while smoking. During an interview with the MDS Nurse on 10/03/2025 at 10:56am it was revealed that she had been trained on MDS. She said the policy for MDS was that staff had 14 days to complete the MDS. She said a resident's pain, ADLs, medication, and therapy go on the MDS. She said the MDS was to be updated quarterly. She said she was responsible for doing the MDS. She said that she was usually notified that a resident was a smoker by the smoking assessment and the morning meeting. She said a resident's smoking status was to be on the MDS. She said she and the social worker were responsible for putting the smoking status on the MDS. She said a lot of different things could happen if a resident's smoking status was not on the MDS. She said a resident could have short breath and staff would not know it was due to smoking. She said she did not know why Resident #105 and Resident #45 did not have the smoking status on their MDS. During an interview with the SW on 10/03/2025 at 11:18am it was revealed she had been trained on MDS. She said the MDS policy was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the MDS had to be done within 14 days. She said the SW, the MDS nurse and the ADM were responsible for doing the MDS. She said everything the resident does, and all the help the resident needs were to be put on the MDS. She said the MDS was to be updated annually and quarterly or when the resident had a significant change. She said she did not know if the resident's smoking status went on the MDS. She said she was notified that the resident was a smoker by the resident, or a caregiver taking care of the resident. She said that she did not inform the MDS nurse of a resident who was a smoker. She said she did not know how it would affect the resident if the smoking status was not on the MDS or not correct on the MDS. She also said she did not know why Resident #105 and Resident #45 did not have their smoking status on the MDS.During an interview with the ADM on 10/03/2025 at 2:04pm it was revealed he had been trained on MDS. He said the policy was that the MDS was to be done on admission, quarterly, annually, and when there was a significant change. He said the MDS Nurse was responsible for completing the MDS. He said information that was on the MDS was the resident's ADLs, therapy, and discharge. He said a resident's smoking status should be on the resident's MDS. He said the MDS nurse was responsible for updating the MDS. He said the MDS nurse was notified of a resident's smoking status through discussion with management, and there was a smoking assessment that was done on the resident. He said if a resident smoking status was not documented on the MDS staff would not be able to get an accurate picture of the plan of care for the resident. He said that he did not know why Resident #105 and Resident #45's smoking status was not on the MDS. When asked for the MDS policy he said they did not have a policy they just follow the RAI. Record review of Centers for Medicare and Medicaid Services Long-Term Care Facilities: RAI 3.0 User's Manual dated October 2025 revealed: J1300: Current Tobacco Use Item Rationale Health-related Quality of Life The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. Planning for Care This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. Steps for Assessment 1. Ask the residents if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions Code 0, no: if there are no indications that the residents used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide accurate PASRR screenings for individuals with a mental disorder for 1 (Resident #5) of 7 residents reviewed for PASRR.The facility failed to complete an accurate PASRR level one screening after Resident #5 was admitted with a negative PASRR Level 1 screening but had a mental illness.The failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included:Record review of Resident #5's undated face sheet, revealed a [AGE] year-old woman admitted to the facility on [DATE]. Resident #5 had diagnosis of hemiplegia and hemiparesis following cerebral infarction (hemiplegia and hemiparesis following cerebral infarction), bipolar disorder unspecified (chronic mental health condition characterized by extreme mood swings between mania) , and major depressive disorder (common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). Record review of Resident #5's quarterly MDS assessment, dated 08/27/2025, did not reflect a diagnosis for requiring a PASSAR II screening. Record review of Resident #5's care plan dated last revised 07/30/2025 revealed Resident #5 has potential for a behavior problem r/t dx bipolar disorder, depression. Resident #5 had a care area resident had e antipsychotic medications r/t Bipolar Disease.Record review of Resident #5's PASRR Level 1 screening, dated 10/16/2024 conducted by director of social services, reflected Resident #5 was negative for mental illness, intellectual disability, and developmental disability. Interview on 10/03/2025 at 1:15PM with MDS A who revealed that the outside facilities are responsible for PASSAR screening before the resident enters the facility. MDS A said that the MDS team is responsible for verifying the information on the PASSAR 1 screenings. MDS A said a diagnosis that would indicate a positive level 1 PASSAR would be any mental illness, bipolar, schizophrenia, IDD diagnosis. MDS A stated a resident that came into the facility with a negative PASSAR 1 and had a diagnosis would indicate the need for a new PASSAR screening. MDS A said an incorrect level 1 PASSAR screening could negatively affect a resident by not receiving the services that they may qualify for. Interview on 10/03/2025 at 1:43PM with the DON revealed she had r3eceived training on resident rights which include the right to refuse services and make informed decisions. The DON said that the MDS team is responsible for inputting PASSAR screenings, as well as to ensure that the screening was correct. Interview on 10/03/2025 at 2:30PM with the ADM revealed he had received training on resident rights which include the right to privacy, the right to be informed, the right to know, and the right to a dignified existence. The ADM said the policy on PASSAR is to obtain a PL1 for anybody coming into the facility from the referring entity. The ADM stated the MDS would put the screening into the system. The ADM said that depending if it is negative or positive will determine if they will come out and assess for a PL2. The ADM said the MDS team is responsible for ensuring the screening is correct. The ADM said a diagnosis of major depressive disorder, an ID or DD would indicate a positive level 1 PASSAR screening. The ADM stated a new diagnosis would require a new PASSAR screening to initiate. The ADM stated if the level 1 PASSAR was incorrect, then the residents could be negatively affected by not receiving a level 2 screening for potential related services.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents receive drinks including water and other liquids consistent with need and preference and sufficient to maintain hydration for 2 of 5 residents reviewed for hydration. (Resident #s 36 and #110).The facility failed to provide water at the bedside for Resident's # 36 and # 110.On multiple occasions throughout the survey process, Resident #36's water pitcher was sitting on her nightstand (approximately 3-5 feet beyond Resident's reach).This failure placed 2 residents at risk for thirst, dehydration, UTI's, and decreased quality of life and could place the residents who were reviewed for hydration at risk for thirst, dehydration and decreased quality of life. Findings included:Record review of Resident #36's Face sheet revealed she is a [AGE] year-old female that was admitted on [DATE]. She has the following diagnoses: Alzheimer's Disease with late onset, (Can Cause memory and cognition issues, impaired judgement, and other symptoms as it progresses.), Type 2 Diabetes Mellitus, (characterized by high levels of sugar in the blood.),Congestive Heart Failure, (a long- term condition where the heart cannot pump blood effectively, leading to fluid accumulation in the lungs and legs.).Record review of Resident # 36's revised care plan dated 09/11/2025 revealed, Regular diet, Pureed texture and regular liquid to be served. intake and record and approach included offer extra fluids with and between meals and to monitor fluid intake. Resident # 36 is at high risk for falls related to confusion, gait and balance problems. Fall mats at bedside when resident is in bed.Record review of the most recent MDS (Minimum Data Set) dated 08/20/2025 indicated Resident #36 had BIMS score of 99 (resident was unable to complete the interview.) Staff Assessment for Mental Status revealed residents were severely impaired and never/rarely made decisions. The MDS indicated he required extensive assistance with bed mobility and ADLs.During an observation on 09/30/2025 at 10:52 am., Resident #36 was lying in bed, she was confused, sleepy and unable to answer questions. Her lips were dry. There was a water pitcher and an empty glass on a dresser table 5-6 feet from the resident's bed. A fall mat was observed between the resident's bed and the dresser tableDuring an observation on 10/03/2025 at 8:15 AM, Resident # 36 was lying in her bed, and no hydration was located within reach of residents. Cup was less than 1/8 filled with water and is 5-6 feet from the resident's bed. Record review of resident # 110's face sheet dated, 10/02/2025 revealed she is an [AGE] year-old female that was admitted on [DATE]. She has the following diagnoses: Acute Kidney Failure, (happens when your kidneys suddenly stop working.), Vascular Dementia, Moderate (moderate dementia is the fourth stage of vascular dementia and is when many people get a diagnosis as the symptoms become more prominent.), Major Depressive Disorder, (Is also known as Clinical depression, its symptoms are feelings of sadness, tearfulness, emptiness or hopelessness.).Record review of Resident # 110's care plan dated 09/17/2025 revealed, the resident has impaired visual function, (resident is blind in 1 eye), The resident has an ADL self-care performance deficit (patient who is not adequately performing the activities of daily living (ADLs).Record review of the most recent MDS (Minimum Data Set) dated 09/22/2025 indicated Resident #110 had BIMS score of 05 (A BIMS score of 5 indicates severe cognitive impairment). The MDS indicated Resident # 110 is dependent regarding mobility, (Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the residents to complete the activity. MDS indicates Resident #110 is independent with eating and drinking (Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.). During an observation on 09/30/2025 @ 10:30 AM. Resident was lying in bed looking up to the ceiling. The residents would intermittently shout unrecognizable words. Resident # 110 was not interviewable. A bed table was located approximately 4 feet to the right of a resident's bed. No water cups or fluid containers were present in resident # 110's room. The room was not homelike; no personal items were observed in this room.During an observation on 10/02/2025 (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:45 P.M, residents #110 was sitting in a wheelchair in the facility dining room. Resident # 110 was observed to be feeding herself and during the lunch meal, independently. Resident #110 was also observed lifting a cup of iced tea to her mouth and drinking independently.During an observation on 10/03/2025 at 2:10 PM, resident # 110 was sitting in her wheelchair in the hallway outside her room. Observation of the interior of room # 110 revealed a cup of water was located approximately 4 feet from resident # 110's bed and it was out of reach of the resident. On 10/03/2025 at 2:20 p.m., the surveyor interviewed CNA C, said she has been trained on resident rights. CNA C stated residents have the right to a dignified existence and their care should include eating and drinking as much as they want. CNA C stated the CNAs are responsible for insuring residents have drinks. She stated the CNA staff should check as often as possible to see if residents have enough to drink. She stated fluids should be on the table close to the resident so they can reach it. CNA C stated dehydration could occur if residents don't have water available to them. CNA C stated she does not know why Resident # 36 water was not within reach of her. In an interview on 10/03/2025 at 2:35 p.m., CNA D said, she has been trained on resident rights and residents have the right to have water and to be paid attention to. CNA D stated the staff should look in on residents every 30 minutes and residents should have liquids within reach of them all the time. She stated CNAs are responsible for insuring residents have drinks. CNA D stated residents could become dehydrated if they don't have water to drink. CNA D stated she has read the facility policy for water and it says they need it! CNA D stated residents should be given water between each meal, in the morning and in the evening. CNA D stated, I don't know why water was not within reach of residents 36 and # 110.In an interview on 10/03/2025 at 3:15 p.m., the Director of Nursing (DON) stated every resident has the right to a dignified existence. Residents have a right to make choices which include the amount of food and drink they want to consume. DON stated she completed online training as a requirement for employment. She stated, I have been trained on resident rights and abuse and neglect. She stated that if a resident does not get enough fluid the resident could become dehydrated, get UTI's and could have altered mental status. DON stated the CNAs are responsible for ensuring residents have drinks and are hydrated. DON stated, residents should be monitored 2 times a day to confirm fluids are available and are within the residents' reach. Monitoring is done by physically observing the room when we do our hydration rounds. DON stated fluids should be placed on a bedside table and moved close to the residents.DON stated she does not know why resident, 36 did not have drinks within reach. DON stated, I think that Resident # 36 may have just been taken to her room after lunch when you looked in on her. She stated resident # 36 is well hydrated during her meals.DON revealed that Resident # 110 often hits her water cups, and they spill on the ground. DON is not aware of any other reason why water was not available to Resident # 110.During an interview with ADM on 10/03/2025 at 3:45 PM, ADM revealed that he has been trained on Abuse, Neglect and resident rights. ADM stated he is the Abuse Coordinator for the facility and all staff should report to him if they suspect abuse. ADM stated, residents have the right to choose what food they eat, and residents have rights to snacks throughout the day. ADM stated, residents should have a dignified existence. He stated, residents could feel discouraged or upset if their needs are not met. ADM stated that the responsibility for ensuring residents have drinks is a collective effort. ADM stated, my expectation is that Department Heads are responsible for doing rounds to monitor the hydration for each resident. ADM revealed, that dehydration, UTI's and other medical complications could occur if residents don't have adequate fluids. ADM stated, water should be provided after meals and at the med pass. ADM stated the nurse is responsible for monitoring staff. ADM stated, I have no Incite as to why resident # 36 and resident # 110 did not have drinks within reach in their rooms. ADM revealed that Resident # 110 has anxiety issues, and it may be more detrimental for her and for others if she has water near to her.Record review of a facility policy, titled Diets, Nutrition and Hydration last revised on 10/24/2022 revealed: 1. Fluid should be available for residents between meals for additional hydration. Fluids will be delivered and/or refreshed a. prior to each meal b. between meals during snack/hydration.

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	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpark Meadows Nursing and Rehabilitation Cente	9801 S 1st Street Austin, TX 78748

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized for 1 of 5 residents (Resident #86) reviewed for pharmacy services. 1. The facility did not follow up on pharmacy consultant recommendation and physician order dated 08/14/2025 to discontinue Hydroxyzine 25mg q24h prn (as needed) for Resident #86.This failure could place the residents at risk for medication errors, unnecessary medications, and incorrect administration. Findings include:Record review of Resident #86's face sheet, dated 10/03/2025, revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia (a progressive and irreversible brain disorder that causes memory loss, cognitive decline, and changes in behavior and personality), chronic kidney disease (condition where the kidneys gradually lose their ability to filter waste products from the blood and maintain fluid balance), and depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities).Record review of Resident #86's quarterly MDS assessment, dated 8/26/2025, revealed a BIMS score of 2 which indicate severe cognitive impairment. Record review of Resident #86's care plan dated 08/16/2025, revealed the resident used anti-anxiety medication related to anxiety disorder. Record review of Resident #86's order summary dated 10/2/2025 revealed an active order for Hydroxyzine HCl Oral table 25 mg (Hydroxyzine HCL) give 1 tablet by mouth every 24 hours as needed for anxiety given prior to personal care ordered on 7/30/2025. Record review of Resident #86's Consultant Pharmacist-Physician Communication dated 07/17/2025 revealed Patient has been taking Hydroxyzine 25mg q24h prn for anxiety since 7/30/2025. PRN orders for psychotropic drugs are limited to 14 days. If the physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he/she must document rationale and indicate the duration for the PRN order. The box next to Physician/Prescriber response was marked agree with order to discontinue this medication signed and dated by physician on 8/14/2025. Record review of Resident #86's medication administration record for months of August and September 2025 revealed Hydroxyzine HCl Oral table 25 mg (Hydroxyzine HCL) give 1 tablet by mouth every 24 hours as needed for anxiety given prior to personal care was not discontinued and identified as an active order, but medication was not administered to Resident #86 during that time. An interview on 10/03/2025 at 12:27 PM with RP revealed he audited the medication records in the facility monthly around 3rd week of the month and made recommendations. He followed up on any changes transcribed to residents' medical records per physician's response to his recommendations. He stated that Hydralazine HCl 25mg for Resident #86 is as needed medication (PRN) and would not be given to her if she does not have signs and symptoms of agitation, so not transcribing the updated order from the physician in this case was a clerical issue. The RP stated that this error did not have potential detrimental effects to the president's health.An interview on 10/03/2025 1:22 PM with ADON revealed he was responsible for transcribing the medication orders from Pharmacist-Physician Communication forms to residents' electronic medical records in the facility. ADON stated that the potential risk from not accurately transcribing the updated order to Resident #86's medication record was a medication error and potential harm with severity depended on medication. An interview on 10/03/2025 1:45 PM with DON revealed the potential risk for not properly transcribing medication orders to residents' medical administration records could lead to medication errors. The DON stated Resident #86 could become over sedated and could be on medications that are no longer indicated. DON stated that ADON was responsible for reviewing Consultant Pharmacist-Physician Communication forms transcribing new orders to residents' medical records. DON stated that new order for Resident #86 to discontinue Hydroxyzine 25mg Q24H prn was not transcribed accurately.An interview on 10/03/2025 2:15 PM with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADM revealed he expected the pharmacy consultants and physician orders to be accurately transcribed to residents' medical records and followed. He stated not accurately transcribing medication orders could potentially harm residents.Record review of Documentation in Medical Record policy dated 10/24/2022 revealed Documentation should be timely and accurate.