STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676459	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedona Trace Health and Wellness Center	8324 Cameron Road Austin, TX 78754

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave for one (Resident #1) of three residents reviewed for discharges, in that: The facility failed to readmit Resident #1 and provide or document sufficient preparation for an orderly discharge when Resident #1 was sent to a behavioral health hospital on 05/22/24. This failure could place residents at risk for not receiving care and services to meet their needs upon discharge, injury, and rehospitalization . 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 Alzheimer's disease (a brain disorder that gets worse over time) with early onset, personal history of Traumatic Brain Injury, schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), major depressive disorder, and other personality and behavioral disorders. Review of Resident #1's quarterly MDS assessment, dated 03/28/24, reflected a BIMS of 3, indicating a severe cognitive impairment. Section E (Behavior) reflected she had hallucinations and delusions as potential indicators of psychosis and physical and verbal behavioral symptoms directed towards others. Review of Resident #1's care plan, revised 03/01/24, reflected she had the potential to demonstrate physical behaviors with an intervention of when she became agitated to guide away from source of stress and engage calmly in conversation. Review of Resident #1's quarterly IDT meeting notes, dated 04/18/24, reflected her RP participated in the meeting. Resident #1's diet, activity preferences, psychiatric services, and therapy services were discussed with no changes. The discharge goal was to remain in long-term care. Review of Resident #1's progress notes, documented on 05/22/24 by LVN A, reflected the following: [Resident #1] was discharged to (psychiatric hospital) in (city), taken by facility transport . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Court Motion for Protective Custody, dated 05/22/24, reflected the following: . Wherefore, premises considered, Movant prays that the Court issue an Order of Protective Custody. Ordering [Resident #1] to be taken into protective custody by a peace officer or other designated person, to be immediately transported to (facility) for observation, evaluation, and examination, and to be detained pending probable cause hearing or further Court order. During an interview on 06/24/24 at 9:43 AM, Resident #1's RP stated there had not been any discussion of a behavioral hospital placement. She stated she was not notified of the transfer until the day she was sent to the hospital, 05/22/24. She stated after her treatment she was sent to a long-term care facility in Waco without any discussion with her. During an interview on 06/24/24 at 12:27 PM, the SW stated Resident #1 had quite a bit of self-harming behaviors and would physically try to strangle herself with her hands. She stated she was aggressive towards staff and other residents and they could no longer safely keep her at the facility. She stated she submitted the OPC and was ordered to send her to a behavioral hospital. She stated the hospital was notified that the facility could not take her back and the hospital staff told them (facility staff) that they could help with placement after her discharge. She stated the hospital had not provided the facility with an update of her treatment. She stated it was not best practice to send a resident to the hospital and not allow them to come back unless there was a legitimate cause such as not being safe to come back. She stated she was not sure if staff had been in-serviced on difficult residents or redirection techniques. During an interview on 06/24/24 at 1:19 PM, the DON stated Resident #1's behaviors had been escalating. She stated she would state that she was going to kill herself and would put her hands around her throat. She stated on one of her more recent hospital visits, the hospital recommended a memory care unit and their facility did not have one. She stated in the past they would be able to tell when she was going to have a behavior and would be able to utilize non-pharmaceutical interventions such as snacks or listening to country music. She stated more recently, there had not been any indications and she would just snap. She stated they had discussed with Resident #1's RP prior to the behavioral health hospital admission regarding finding a better facility that was more suitable to meet her needs, but her RP was not interested in transferring her. She stated she was admitted to the psychiatric hospital and it was discussed with them prior to admission if they would be able to find placement for her after treatment. She stated the facility was under the impression she would have somewhere to go to after treatment. She stated the plan when she was admitted to the psychiatric hospital was for her not to be readmitted to the facility. She stated normally when you send a resident out, the goal was for them to get the help the need and then return to the facility. She stated their psychiatrist had maxed out on medications and the providers felt she was not appropriate for their facility. She stated they did not provide a 30-day discharge notice to the resident or family. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 2:05 PM, the ADM stated her expectation for the discharge process was if a resident was sent out to the hospital, they would give out a bed-hold notice, would review updates from the hospital, would look at their baseline after they were stabilized, and would readmit them if they could still meet their needs. She stated with Resident #1, she was not appropriate for their facility and they were unable to meet her needs. She stated she spoke to a staff at the psychiatric hospital a day or so after she was admitted (05/22/24) and gave them options of facilities with locked units. She stated she had been sent out to the hospital on two occasions for suicidal ideations and had returned with her behaviors being much worse. She stated she was very impulsive and would hit and kick staff. She stated their IDT met with her RP, NP, and psychiatrist and they discussed that she was no longer appropriate for their facility and needed a higher level of care where psychiatric services were provided in-house daily. Review of the facility's Admission, Transfer, and Discharge Policy, revised 01/2024, reflected the following: 9. If the facility determines that a resident, who was transferred with an expectation of returning to the facility, cannot return to the facility, this constitutes a discharge and this policy shall apply.