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	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedona Trace Health and Wellness Center	8324 Cameron Rd. 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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's responsible party has the right to exercise the resident's rights for one (Resident #1) of seven residents reviewed for resident rights.The facility failed to ensure Resident #1's POA, FM A, notified when the resident was discharged from facility with FM B.This failure could place residents at risk of not having their preferred responsible party represent them in a medical, nursing care and safe discharge decisions.Findings included:Record review of Resident #1's face sheet dated 05/12/26 revealed a [AGE] year-old female, admitted on [DATE] with diagnosis of pneumonia, anemia, major depressive disorder, muscle weakness, reduced mobility and need for assistance with personal care. It was also revealed that FM A was one of the two POAs for financial and care and emergency contact #1 and FM B the emergency contact #2 ,sharing POA rights with FM A.Record review of Statutory Durable Power of Attorney executed on 09/14/2010, duly signed by Resident #1 revealed that FM A was her primary POA while FM B would act as the alternate POA for Resident #1. The document reflected that FM A s would be Resident #1's agent (attorney-in-fact) to act for her in any lawful way and FM B should act as her substitute or successor agent only if FM A for any reason fail or ceases to act as her POA.Record review of Resident #1's discharge MDS dated [DATE] revealed a BIMS score of 14, indicating her cognition was intact. The MDS indicated that she needed supervision with showering and used manual wheelchair for mobility. It was also revealed that she was frequently incontinent with bowel and bladder.Record review of Resident #1's care plan dated 04/07/26 revealed she wished to return/be discharged to her home. The interventions for a safe discharge were:Establishing a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan as needed.Making arrangements with required community resources to support independent post-discharge.Preparing and giving resident, family member and care giver contact numbers for all community referrals, andProviding any needed support by the staffThe care also revealed Resident #1 had ADL Self Care Performance Deficit r/t generalized weakness . The relevant intervention was providing one staff assistance.Record review of the ?Resident admission Agreement' dated 04/09/26 revealed the source of payment was Medicare.Record review of the Notice of Medicare non-coverage dated 04/15/26 revealed the Medicare coverage for the current skilled nursing facility services would end on 04/17/26 . The Notice of Medicare non-coverage dated 04/22/26 revealed the Medicare coverage for the skilled nursing facility services at that time would end on 04/24/26.Record Review of the progress note of Resident #1 dated 04/26/26 at 8:00pm , authored by RN C reflected : [FM B] requested for discharge and DON notified of the decision and she said resident can go home with meds and discharge instructions given and home meds given. Resident left with the family members in good condition. v/s within normal limit.During a phone interview on 05/12/26 at 3:00pm RN C stated on 04/26/26 FM B approached her and requested the discharge of Resident#1. RN C said she got the permission from DON over the phone and sent Resident #1 with FM B. She stated she did not let FM A know about the discharge before or after the discharge as Resident #1 was going with her FM who was also a POA.During a telephone interview conducted on May 12, 2026, at 9:55 a.m., FM A stated that he resides in a city distant from the facility. He reported that the second appeal regarding (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the NOMNC, dated April 24, 2026, was denied. He said, as the POA, he determined that Resident #1 should remain at the facility until a reliable home health care arrangement could be organized. He said he undertook the financial responsibility for retaining Resident #1's bed at the facility until a safe discharge arrangement was done. FM A said , although FM B resides in close proximity to the facility and expressed willingness to care for Resident #1 at her home, he was dissatisfied with this arrangement. He stated Resident #1 requires specialized care due to her age and complex medical needs, which FM B was not qualified or able to provide. He stated he was not happy with the discharge of Resident #1 to FM B on April 26, 2026 noting that the discharge occurred without consulting him, despite his role as the primary POA. He stated the facility neither sought nor received his input before or after the discharge. He learned of the discharge on ly when FM B took Resident #1 home. FM A stated that this lack of communication was unacceptable and raised concerns about the Resident #1's well-being. He said, had the facility contacted him prior to the discharge, he would not have authorized FM B to take Resident #1 home, as this was not his intended plan. This was also the reason he decided to keep Resident #1 at the facility despite Medicare's denial of coverage, which led him to pay out-of-pocket for the nursing facility expenses after the appeal was rejected. FM A stated that the discharge was unsafe, as FM B lacked the necessary resources and capabilities to care for Resident #1, a [AGE] year-old with multiple complex medical and physical conditions requiring skilled nursing care.During an interview on 05/12/26 at 10:35 a.m., the SW stated that he had begun working at the facility approximately one month prior and was aware of Resident #1 and her discharge. He indicated that he had met FM A once previously and discussed Resident #1's care at that time; however, there was no discussion regarding the discharge. The SW reported that both FM A and FM B were actively involved in Resident #1's care and FM B visited her regularly than FM A at the facility. He said that both FM A and FM B served as the POA for Resident #1. The SW stated that FM A wished for Resident #1 to remain at the facility and had been paying out of pocket for her stay since April 24, 2026, when Medicare ceased coverage. Conversely, FM B preferred to discharge Resident #1 to her home. The SW stated he had noticed some family dynamics influencing the decision-making process regarding Resident #1's care. He stated that Resident #1 was discharged on April 26, 2026, and FM B took her to her apartment in a flat located on 2nd floor. He stated that he did not consult FM A regarding the discharge plan; however, he informed him of the discharge on [DATE]. The SW expressed the opinion that the facility should have sought FM A's permission before discharging Resident #1, especially considering that FM A was the primary POA and the designated emergency #1 contact, and there were family dynamics involved in the situation. The SW stated he contacted FM A next day after the discharge and informed him about the discharge details.During an interview on 05/12/26 at 10:50 a.m., the DC stated that he had a supportive role in handling discharge activities and had processed the discharge of Resident #1. He indicated that, based on the decision made by the IDT, Resident #1 was discharged on April 26, 2026, to FM B's home, as FM B wanted to take her. He also stated that he never contacted FM A regarding Resident #1's discharge. He also stated that he never contacted FM A regarding Resident #1's discharge as FM B was there with Resident #1 during the discharge who also a POA.During a phone interview on 05/12/26 at 11:00 a.m., FM B stated that FM A was not directly involved in Resident #1's care, as he lives out of the city and preferred that Resident #1 remain at the facility. FM B stated however her desire to take Resident #1 home, in accordance with Resident #1's wishes.During an interview on 05/12/26 at 11:35 a.m., the ADON stated there were significant family dynamics influencing the situation between FM A and FM B. She said she had noticed that FM A appeared more sensible and responsible, strongly preferring that Resident #1 remain at the facility. In contrast, FM B wished to discharge Resident #1 and take her home. The ADON mentioned that FM A was even willing to pay out of pocket to ensure Resident #1's continued stay at the facility when Medicare coverage was denied. She stated that, given FM A's role as the primary emergency contact and his active involvement in Resident #1's care, the facility should have consulted with him prior to making the discharge decision.During an interview on 05/12/26 at (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:30 p.m., the DON stated that she was not aware that Resident #1 had been discharged to an independent house. The DON stated that discharging Resident #1 to FM B was the correct decision, citing that FM A lives far away in another city, whereas FM B resides nearby and was capable of caring for Resident #1 at home. She also stated that the EHR incorrectly listed FM A as the primary emergency contact, asserting that it should have been FM B. She stated that she decided to discharge Resident #1 with FM B because FM B was the designated POA #1 as per understanding and she did not believe it was necessary to inform FM A of the discharge, considering his distant location. When the investigator pointed out that it was clearly evident from the POA document that FM A was the primary POA , the DON stated she could check out the documents in E H R and confirm about this.During a follow-up telephone interview conducted as a return call on 05/13/26 at 7:36 a.m., FM A stated that Resident #1 resides in her own house. FM A further stated that no representative, including SW from the facility contacted him before or after the discharge. FM A stated that he had made numerous phone calls to the facility and left messages related to Resident #1's care , financial issues and discharge plans, however for none of them he received a return response. He indicated that he would not have been informed of the discharge at all if FM B had not notified him. He stated that the facility's lack of communication and professionalism was a type of neglect, asserting that it disrupted his discharge plans for Resident #1 for a comfortable and safe living arrangement. He expressed a desire to hold the facility accountable for these actions.Record review of facility policy Federal Resident Rights revised on 02/24/22 reflected : As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States.receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language you understand a decision to transfer or discharge you from the facility; .Record review of the facility policy Discharge Planning Process revised in January 2026 reflected: It is the policy of the facility that the discharge planning process focuses on the resident's discharge goals involving the residents as active partners. The discharge process should effectively transition them to post discharge care and minimize clinical or other factors which are related to the possibility of a readmission.Procedure:The facility's discharge planning process shall:.f. Involve the resident and resident representative when necessary in the development of the discharge plan and inform the resident and resident representative of the final plan.

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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 reviews and interviews, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for 1 (Resident #1) of 3 residents reviewed for safe transfer or discharge.The facility failed to ensure the safety of Resident #1 when she was discharged on 04/26/26 with FM B. This failure could result in the safety of the residents who are discharged from the facility.Findings included:Record review of Resident #1's face sheet dated 05/12/26 revealed a [AGE] year-old female, admitted on [DATE] with diagnosis of pneumonia, anemia, major depressive disorder, muscle weakness, reduced mobility and need for assistance with personal care. It was also revealed that FM A was one of the two POAs for financial, care and emergency contact #1 and FM B the emergency contact #2 ,sharing POA rights with FM A.Record review of Statutory Durable Power of Attorney executed on 09/14/2010, duly signed by Resident #1 revealed that FM A was her primary POA while FM B would act as the alternate POA for Resident #1. The document reflected that FM A s would be Resident #1's agent (attorney-in-fact) to act for her in any lawful way and FM B should act as her substitute or successor agent only if FM A for any reason fail or ceases to act as her POA.Record review of Resident #1's discharge MDS dated [DATE] revealed a BIMS score of 14, indicating her cognition was intact. The MDS indicated that she needed supervision with showering and used manual wheelchair for mobility. It was also revealed that she was frequently incontinent with bowel and bladder.Record review of Resident #1's care plan dated 04/07/26 revealed she wished to return/be discharged to her home. The interventions for a safe discharge were:Establishing a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan as needed.Making arrangements with required community resources to support independent post-discharge.Preparing and giving resident, family member and care giver contact numbers for all community referrals, andProviding any needed support by the staff.The care also revealed Resident #1 had ADL Self Care Performance Deficit r/t generalized weakness . The relevant intervention was providing one staff assistance.Record review of the ?Resident admission Agreement' dated 04/09/26 revealed the source of payment was Medicare.Record review of the Notice of Medicare non-coverage dated 04/15/26 revealed the Medicare coverage for the current skilled nursing facility services would end on 04/17/26. The Notice of Medicare non-coverage dated 04/22/26 revealed the Medicare coverage for the current skilled nursing facility services would end on 04/24/26.Record Review of a progress note of Resident #1 dated 04/26/26 at 8:00pm, authored by RN C reflected: [FM B] requested for discharge and DON notified of the decision and she said resident can go home with meds and discharge instructions given and home meds given. Resident left with the family members in good condition. v/s within normal limit.During a telephone interview conducted on 05/12/26, at 9:55 a.m., FM A stated that he resided in a city distant from the facility. He reported that the second appeal regarding the NOMNC, dated 04/26/26, was denied. He said, as the primary POA he determined that Resident #1 should remain at the facility until a reliable home health care arrangement could be organized. He said he undertook the financial responsibility for retaining Resident #1's bed at the facility until a safe discharge arrangement was done. FM A said although FM B resided in close proximity to the facility and expressed willingness to care for Resident #1 at her home, he was dissatisfied with that arrangement. He stated that Resident #1 required specialized care due to her age and complex medical needs, which FM B was not qualified to provide. He stated he was not happy with the discharge of Resident #1 to FM B on 04/26/26 noting that the discharge occurred without consulting him, despite his role as the primary POA. He stated that the facility neither sought nor received his input before or after the discharge. He learned of the discharge on ly when FM B took Resident #1 home. FM A stated that the lack of communication was unacceptable and raised concerns about the Resident #1's well-being. He (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said had the facility contacted him prior to the discharge he would not have authorized FM B to take Resident #1 home, as he knew FM B did not have the capacity to look after Resident #1. He stated that was also the reason he decided to keep Resident #1 at the facility despite Medicare's denial of coverage, which led him to pay out-of-pocket for the nursing facility expenses after the appeal was rejected. FM A stated the discharge was unsafe, as FM B lacked the necessary resources, skills and capabilities to care for Resident #1, a [AGE] year-old with multiple complex medical and physical conditions requiring skilled nursing care. During an interview on 05/12/26 at 10:35 a.m., the SW stated that he had begun working at the facility approximately one month prior and was aware of Resident #1 and her discharge. He indicated that he had met FM A once previously and discussed Resident #1's care at that time; however, there was no discussion regarding the discharge. The SW reported that both FM A and FM B were actively involved in Resident #1's care and unlike FM A , FM B visited her regularly at the facility. He said that both FM A and FM B served as the POA for Resident #1. The SW stated that FM A wished for Resident #1 to remain at the facility and had been paying out of pocket for her stay since 04/24/26, when Medicare ceased coverage. The SW stated conversely, FM B preferred to discharge Resident #1 to her home. The SW stated he had noticed some family dynamics influencing the decision-making process regarding Resident #1's care. He stated that Resident #1 was discharged on 04/26/26 and FM B took her into a flat located on the 2nd floor of her apartment . The SW stated he was unaware of the condition of the apartment or if the building had an elevator as he neither inquired about it with anyone nor visited the residence to observe the living arrangement. He stated that he did not consult FM A regarding the discharge plan; however, he informed him of the discharge on [DATE]. The SW expressed the opinion that the facility should have sought FM A's permission before discharging Resident #1, especially considering that FM A was the primary POA and the designated emergency #1 contact, and there were family dynamics involved in the situation. During an interview at 3:20pm, when clarified with SW that Resident #1 lived in her own house and FM B in a trailer, contrary to his understanding during the discharge process, the SW stated he was sure that FM B reported to him that she lived in an apartment and Resident # 1 was going to live there. He stated he was not aware of any independent house owned by Resident #1 and if the house was in a livable condition. During an interview on 05/12/26 at 10:50 a.m., the DC stated that he had a supportive role in handling discharge activities and had processed the discharge of Resident #1. He indicated that based on the decision made by the IDT Resident #1 was discharged on 04/26/26, to FM B's home, as FM B wanted to take her. The DC reported that according to FM B she resided on the second floor of an apartment. He said that he was unsure how Resident #1 would access the first floor in case of an emergency and was also uncertain whether an elevator was available in the building. Additionally, he stated he did not verify whether FM B actually lived in an apartment, despite her assertion to that effect.The DC stated that he did not consider potential safety concerns related to Resident #1 living on the second floor of an apartment. He mentioned that he provided all relevant information regarding post-discharge services to FM B. He also stated that he never contacted FM A regarding Resident #1's discharge as FM B was there with her who also a POA.During a phone interview one 05/12/26 at 11:00 a.m., FM B stated that she resided in a trailer and that Resident #1 lived in her own independent house close to her trailer. She explained that other family members, friends, and herself took turns caring for Resident #1. FM B stated that she had never lived in an apartment and was unaware of the source of the incorrect information indicating that Resident #1 lived on the second floor of an apartment. She further stated that FM A was not directly involved in Resident #1's care, as he lived out of the city and preferred that Resident #1 remain at the facility. FM B stated however her desire to take Resident #1 home, in accordance with Resident #1's wishes.During an interview on 05/12/26 at 11:35 a.m., the ADON stated that she was well acquainted with FM B and her family. She reported having a close professional relationship with FM B, as another family member of FM B was also a long-term resident at the facility whom the ADON used to care for personally. She stated that FM B used to visit her regularly at the facility. The ADON stated there (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were significant family dynamics influencing the situation between FM A and FM B. She said she had noticed that FM A appeared more sensible and responsible, strongly preferring that Resident #1 remain at the facility. The ADON stated In contrast, FM B wished to discharge Resident #1 and take her home. The ADON mentioned that FM A was even willing to pay out of pocket to ensure Resident #1's continued stay at the facility when Medicare coverage was denied. The ADON said that Resident #1 was discharged to her own house, not an apartment, and expressed ignorance regarding the origin of the information suggesting Resident #1 was living on the second floor of an apartment. The ADON stated she was under the impression that the SW, DC and DON were all aware of Resident #1's actual living arrangement.The ADON also reported that FM B told her that one day a person from LEA appeared on her doorstep, asked questions, and she was unsure of the reason for their visit. She stated that given FM A's role as the primary emergency contact and his active involvement in Resident #1's care including financial matters, the facility should have consulted with him prior to making the discharge decision.During an interview on 05/12/26 at 12:30 p.m., the DON stated that she was not aware that Resident #1 had been discharged to an independent house. She said that based on discussions with other healthcare professionals Resident #1 was believed to have been discharged to a flat situated on the second floor of an apartment. The DON said that she was not informed of any involvement by LEA following the discharge, as no personnel at the facility reported such an incident to her. The DON stated that discharging Resident #1 to FM B was the correct decision, citing that FM A lived far away in another city, whereas FM B resided nearby and was capable of caring for Resident #1 at home. She also stated that the EHR incorrectly listed FM A as the primary emergency contact, asserting that it should have been FM B. She stated that she decided to discharge Resident #1 with FM B because FM B was the designated POA #1 as per understanding, and she did not believe it was necessary to inform FM A of the discharge, considering his distant location. When the investigator pointed out that it the POA document reflected FM A was the primary POA, the DON stated she could check out the documents in EHR and confirm it. She said there were significant family dynamics between FM A and FM B and indicated that the facility should have verified Resident #1's living and safety conditions and the appropriateness of the discharge destination before proceeding, rather than relying solely on the information provided by FM B.During a follow-up telephone interview conducted as a return call on 05/13/26 at 7:36 a.m., FM A stated that Resident #1 resided in her own house. He explained that FM B and other family members, who previously lived in a trailer, now resided with Resident #1 to provide care. FM A expressed uncertainty regarding the arrangement and voiced concerns about Resident #1's safety. FM A further stated that no representative from the facility contacted him before or after the discharge. He indicated that he would not have been informed of the discharge at all if FM B had not notified him. He stated that the facility's lack of communication and professionalism was a type of neglect, asserting that it disrupted his plans for Resident #1's comfortable and safe living environment. Additionally, FM A reported that he contacted the local LEA to conduct a wellness check on Resident #1 to make sure that the house was in a living condition without any safety hazards. He said the LEA subsequently contacted him after their visit, informing him that the house was currently livable and that Resident #1 was safe. FM A explained that he was aware of FM B's limitations in caring for Resident #1, he recently organized a home health agency to provide her with necessary care, bearing the associated expenses himself. He stated that since the discharge, Resident #1's condition has deteriorated, receiving hospice care as she was nearing towards the end of her life. FM A stated that FM B and her family continued to live with Resident #1 in her home, assisting with her needs.Record review of the facility policy Discharge Planning Process revised in January 2026 reflected: It is the policy of the facility that the discharge planning process focuses on the resident's discharge goals involving the residents as active partners. The discharge process should effectively transition them to post discharge care and minimize clinical or other factors which are related to the possibility of a readmission.Procedure:The facility's discharge planning process shall:a. provide and document sufficient preparation and orientation to residents in a (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form and manner that the resident can understand to ensure safe and orderly transfer or discharge from the facility.b. Ensure that the discharge needs of each resident are identified on admission and that a discharge plan for each resident is developed and implemented in a timely manner.e. Consider caregiver/support person availability and resident's or caregiver's/support person's capacity and capability to perform required care . as part of the identification of discharge needs.f. Involve the resident and resident representative when necessary in the development of the discharge plan and inform the resident and resident representative of the final plan. Record review of Resident admission agreement dated 04/09/26, duly signed by Resident #1 reflected : XI. TERMINATION, TRANSFER, OR DISCHARGE(A). Involuntary Transfer or discharge: The Facility shall not involuntarily transfer or discharge the Resident, except if. (5) the Resident, Resident Representative, family member, or legal representative of the Resident, if known to the Facility, requests a voluntary transfer or discharge.(C). Voluntary discharge: The Resident, or Resident Representative to the extent legally authorized, shall have the right at all times to voluntarily discharge the Resident from the Facility, provided that the Administrator of the Facility is given prior notification in order that a proper transfer or discharge can be effected. The Facility requires fourteen (14) days advance written notice of a planned discharge or transfer and the Resident may be charged for such days.