STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676487	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Parmer	13800 N Fm 620 Rd Sb Austin, TX 78717

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 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 interviews and record reviews, 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 6 residents reviewed for discharge planning. 1. 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 06/11/25. 2. The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #1 was discharged from the facility on 06/11/25. 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: Review of Resident #1's Profile, dated 06/23/25, reflected she was a [AGE] year old female who was admitted to the facility on [DATE] and discharged from the facility on 06/11/25. Review of Resident #1's Medical Diagnoses Report, dated 06/23/25, reflected she had diagnoses of hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left dominant side, dysphagia following cerebral infarction (difficulty swallowing), age-related physical debility (a state of weakness and reduced physical strength), generalized muscle weakness, unsteadiness on feet, other lack of coordination, anxiety disorder, anorexia (an eating disorder causing people to obsess about weight and what they eat) and depression. Review of Resident #1's admission MDS, dated [DATE], reflected she had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. Resident #1 also always needed help with health literacy (assistance with reading written material related to health) and was dependent on assistance with her functional cognition (assistance with planning regular tasks). (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care Plan, initiated on 03/03/25, reflected she wanted to establish goals for herself and be involved in her discharge planning process. Staff were also required to communicate with Resident #1 and/or her family related to progress, goals and plans, contact appropriate community agencies as needed when Resident #1 was ready to discharge, continue to encourage Resident #1 to make an effort toward achieving their goals, and Resident #1 wanted to go home when she discharged . Review of Resident #1's Progress Notes, from 03/03/25 through 06/23/25, reflected there were no notes related to a written notice of discharge and reasons for the move given to Resident #1, Resident #1's RP, and the facility's Ombudsman. Review of Resident #1's Electronic Health Records on 06/23/25 reflected there was no written notice of discharge and reasons for the move given to Resident #1, Resident #1's RP, and the facility's Ombudsman. Review of Resident #1's IDT Discharge Summary, created by CM on 06/10/25 at 1:07 p.m., reflected she was discharged on 06/11/25 at 12:00 p.m. with hospice, a wheelchair and a mechanical lift, would continue physical therapy and medication management, and transported in a private vehicle to her home. The section of the summary in which the discharge instructions were to be reviewed with Resident #1 or Resident #1's RP in a language they understand was not signed and not dated by Resident #1, Resident #1's RP, and CM or discharging nurse. An attempt to contact the facility's Ombudsman was made on 06/23/25 at 9:50 a.m. The facility's Ombudsman did not return the surveyor's attempted contact before exit. During an interview on 06/23/25 at 9:54 a.m., Resident #1's RP stated the facility did not provide her and Resident #1 with a written 30-day notice that they were discharging Resident #1 on 06/11/25. Resident #1's RP stated she learned that Resident #1 was discharging from the facility by a medical equipment provider who called her on 06/06/25. Resident #1's RP stated she called the CM on 06/06/25 and the CM told her that Resident #1 was being discharged from the facility on 06/11/25 because she was coming up to her 100 days of covered stay at the facility. Resident #1's RP stated she informed the CM and ADM about her concerns of not being notified of Resident #1's discharge in advance on unknown date . Resident #1's RP also stated the facility did not inform her and Resident #1 of Resident #1's right to appeal the discharge and the appeal process. During an interview on 06/23/25 at 1:23 p.m., the ADON stated the CM was responsible for notifying residents, residents' RPs and the Ombudsman in writing of residents' discharge from the facility. The ADON stated she spoke with the facility's Corporate team and learned that the facility was required to send a written discharge notice to residents, residents' RPs and the Ombudsman within 30 days of discharge per the facility's policy. The ADON stated she did not know the facility was required to send a written 30-day notice of discharge to residents, RPs and Ombudsman because the facility's policy was vague. The ADON stated the facility did not comply with the regulation for providing a written 30-day notice of discharge to residents, residents' RPs, and the Ombudsman. During an interview on 06/23/25 at 1:56 p.m., Resident #1's RP stated Resident #1 was unable to answer the surveyor's questions due to her severe cognitive impairment. Resident #1's RP also stated the Administrator told her that she did not have to be informed of Resident #1's discharge three days before Resident #1's discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/23/25 at 2:28 p.m., the CM said she was responsible for issuing a formal written notice of discharge to residents, residents' RPs, and the Ombudsman. The CM stated she did not provide Resident #1, Resident #1's RP, and the Ombudsman with a written notice of discharge because she did not know she had to provide a formal written notice of discharge to the resident, residents' RP, and Ombudsman within 30 days of a resident's discharge from the facility. The CM also stated she did not inform Resident #1 and Resident #1's RP of Resident #1's right to appeal the discharge and the appeal process for unknown reasons. The CM stated she knew it was important to provide a notice of discharge in writing to the resident, representative and Ombudsman at least 30 days before a resident is discharged and said, So residents' families knew when, where, why and how the resident was discharging from the facility. So the Ombudsman was aware of the resident's discharge. The CM stated she knew it was important to inform the resident and residents' RPs of residents' right to appeal their discharge and the appeal process and said, Because residents must know their right to appeal. The CM stated the ADM was responsible for overseeing and ensuring the discharge process was correctly completed. The CM stated the ADM was out of the country at the time of the interview. During an interview on 06/23/25 at 2:59 p.m., the DON stated Resident #1 had a low BIMS and could not make decisions for herself. The DON stated the CM was responsible for initiating the notice of discharge to the resident, resident's RP, and Ombudsman. The DON stated the CM did not provide a written notice of discharge to Resident #1, Resident #1's RP, and the Ombudsman. The DON stated she knew it was important to provide a written notice of discharge to residents, residents' RPs, and the Ombudsman within 30 days of a resident's discharge from the facility and said, You have to notify the appropriate parties to ensure the resident discharge safely and to be able to follow-up with necessary agencies and make sure resident was safe and provided continued care from the facility when transitioning back to home and so family was equipped when receiving the resident. And so the Ombudsman could ensure and had a role in resident being well taken care of and it was important for continuity of care for the resident and to make sure to communicate all discharge plans and interventions the resident needed for the resident's welfare. The DON stated the ADM was responsible for overseeing and ensuring the CM correctly completed the discharge process. Review of the facility's Transfers and Discharges policy, undated, reflected, .Any transfer or discharge not meeting regulatory standards or that places the resident at risk is considered inappropriate and is strictly prohibited .Discharges are inappropriate and unlawful if they occur under any of the following conditions: .2. Failure to provide written notice: Not giving the required 30-day written notice to the resident and their representative .Procedure for Transfer or discharge: .Notice Requirements: The facility must provide 30 days written notice of discharge to the resident and their legal representative .Notice must include: Reason for discharge, effective date, location to which the resident is being transferred, contact information for: state long-term care ombudsman, state survey agency, appeal rights and process, resources for assistance .5. Residents and their representatives must be informed of their right to appeal a discharge . 6. Involuntary Discharges: .The Ombudsman program must be notified before the discharge is initiated .Staff Responsibilities: Admissions and Social Services: Ensure that transfers and discharges are carried out in accordance with this policy, providing support and proper documentation .Administrator: .inform the Ombudsman . Review of the facility's Resident Rights policy, undated, reflected, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Social Services: The Center must provide you with any needed medically-related social services, including . discharge planning .You can't be sent to another nursing home or be made to leave The Center .You (and your representative) have a right to be notified before you are transferred or discharged from The Center . Your rights include: .The right to remain in the facility: The right to not be transferred or discharged .and to be given 30 days advance notice .