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	11/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of five residents reviewed for quality of care. The facility delayed Resident #1's catheter care for approximately 2.50 hours on 09/02/25 resulting in Resident #1 having discomfort and pain. This failure could place residents at risk of discomfort and pain, a decrease in their quality of life, quality of care, and dignity.Findings included:Record review of Resident #1's face sheet, dated 09/13/25, revealed a forty-one-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included paraplegia (damage to the spinal cord, the bundle of nerves that connects the brain to the lower body), major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and ankylosing spondylitis of multiple sites in spine (an inflammatory disease that, over time, can cause some of the bones in the spine, called vertebrae, to fuse).Record review of Resident #1's care plan revealed a focus dated 01/03/25 of self-catheter (a way for you to empty your own bladder) and intervention dated 01/03/25 monitor and document intake and output. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 04/09/25 revealed a score of 15, indicating he was cognitively intact.Review of Resident #1's orders reflected in and out catheter (flexible tube called a catheter was inserted to drain fluids from the body) every 6 hours four times a day start date 01/05/2025 4:00 am, 10:00 am, 4:00 pm, and 10:00 pm. Review of Resident #1's MAR dated 09/02/25 for in and out catheter every 6 hours four times a day reflected Resident #1 received catheter care at 4:00 am with a urine output of 1100 ml, 10:00 am with a urine output of 900 ml, no entry for 4:00 pm, and 10:00 pm with urine output of 1500 ml.Interview on 09/13/25 at 12:06 pm with the ED reflected Resident #1 had an in and out catheter but Resident #1 did not like to do his own catheter care. The facility did it for them. The facility staff were trying to get him as independent as possible. Interview on 09/13/25 at 11:00 am with Resident #1 reflected the facility did not provide catheter care on 09/02/25 for about 2.5 hours after it was scheduled and he was in massive pain. He said it hurt until 4:00 am and they had to give him a pain pill. He said he heard someone in the hallway tell the ADON that he needed to have his catheter care, but the ADON said she would get to it when she had a chance. He said he asked two times to have his catheter emptied but no one came until about 2 hours later. He said he hurt so bad he had to ask for a pain pill. He said he felt that because they did not provide the catheter care on 09/02/25, it caused him to have a urinary tract infection. Interview on 09/13/25 at 3:41 pm with the NP reflected the facility told her that Resident #1 did not receive catheter care until approximately 6:00 pm on 09/02/25. Resident #1 refused to do catheter care on his own. Resident #1 told her on 09/02/25 he did not receive catheter care until approximately 2 hours later than he was supposed to have received catheter care and this caused a urinary tract infection. She said when he was tested a day or so after 09/02/25 (date of test unknown) he was positive for a urinary tract infection. The NP said the positive urinary tract infection cannot be directly related to the not being tapped (bladder stimulation by tapping to help empty the bladder) on 09/02/25 approximately 2 hours after it was scheduled. She was not sure when he was last catheterized prior to the approximately 6:00 pm catheterization. She said a bladder can retain urine and enlarge but when they were able to catheterize him approximately 2 hours later than he was usually catheterized, there was not a great deal of urine in his bladder. She said a full bladder was 600 ml to 650 ml and up and that was way too much for one bladder. She could not recall how much urine was in Resident #1's bladder when they catheterized him at approximately 6:00 pm. She said Resident #1 told him the story of the late cauterization the next day, 09/03/25, but he did not seem to be too upset about it and Resident #1 told her everything had improved, and everything was better. She said Resident #1 did not complain to her he was having symptoms of pain or discomfort. She said she had no concerns about his care at the facility. She said Resident #1 was afraid to do the in and out catheter self-care. She said he was not harmed at all by the situation of him getting catheterized approximately 2 hours late on 09/02/25 and she was not concerned at all about the nursing care treatment Resident #1 received at the facility. Interview on 09/13/25 at 5:35 pm with LVN A reflected Resident #1 had an in and out catheter and nursing staff had to assist him with his catheter. He said Resident #1 was care planned for a self-catheter, but the nurses had to make sure the catheter tubing went

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure the medical record on each resident was complete and accurately documented for one (Resident #1) of five residents reviewed for accurate medical records. The facility documented in Resident #1's MAR that he received catheter care at 10:00 pm on 09/02/25 when Resident #1 stated he received catheter at approximately 6:30 pm on 09/02/25.This failure could place residents at risk of misdiagnosis, incorrect treatment, and poor quality of life.Findings included:Record review of Resident #1's face sheet, dated 09/13/25, revealed a forty-one-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included paraplegia (damage to the spinal cord, the bundle of nerves that connects the brain to the lower body), major depressive disorder (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and ankylosing spondylitis of multiple sites in spine (an inflammatory disease that, over time, can cause some of the bones in the spine, called vertebrae, to fuse).Record review of Resident #1's care plan revealed a focus dated 01/03/25 of self-catheter (a way for you to empty your own bladder) and intervention dated 01/03/25 monitor and document intake and output. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 04/09/25 revealed a score of 15, indicating he was cognitively intact.Review of Resident #1's orders reflected in and out catheter (flexible tube called a catheter was inserted to drain fluids from the body) every 6 hours four times a day start date 01/05/2025 4:00 am, 10:00 am, 4:00 pm, and 10:00 pm. Review of Resident #1's MAR dated 09/02/25 for in and out catheter every 6 hours four times a day reflected Resident #1 received catheter care at 4:00 am with a urine output of 1100 ml, 10:00 am with a urine output of 900 ml, no entry for 4:00 pm, and 10:00 pm with urine output of 1500 ml. Interview on 09/13/25 at 12:06 pm with the ED reflected Resident #1 had an in and out catheter but Resident #1 did not like to do his own catheter care. The facility did it for them. The facility staff were trying to get him as independent as possible. Interview on 09/13/25 at 11:00 am with Resident #1 reflected the facility did not provide catheter care on 09/02/25 for about 2.5 hours after it was scheduled and he was in massive pain. He said it hurt until 4:00 am and they had to give him a pain pill. He said he heard someone in the hallway tell the ADON that he needed to have his catheter care, but the ADON said would get to it when she had a chance. He said he asked two times to have his catheter emptied but no one came until about 2 hours later. He said he hurt so bad he had to ask for a pain pill. He said he felt that because they did not provide the catheter care on 09/02/25, it caused him to have a urinary tract infection. Interview on 09/13/25 at 3:41 pm with the NP reflected the facility told her that Resident #1 did not receive catheter care until approximately 6:00 pm on 09/02/25. Resident #1 refused to do catheter care on his own. Resident #1 told her on 09/02/25 he did not receive catheter care until approximately 2 hours later than he was supposed to have received catheter care and this caused a urinary tract infection. She said when he was tested a day or so after 09/02/25 (date of test unknown) he was positive for a urinary tract infection. The NP said the positive urinary tract infection cannot be directly related to the not being tapped (bladder stimulation by tapping to help empty the bladder) on 09/02/25 approximately 2 hours after it was scheduled. She was not sure when he was last catheterized prior to the approximately 6:00 pm catheterization. She said a bladder can retain urine and enlarge but when they were able to catheterize him approximately 2 hours later than he was usually catheterized, there was not a great deal of urine in his bladder. She said a full bladder was 600 ml to 650 ml and up and that was way too much for one bladder. She could not recall how much urine was in Resident #1's bladder when they catheterized him at approximately 6:00 pm. She said Resident #1 told him the story of the late cauterization the next day, 09/03/25, but he did not seem to be too upset about it and Resident #1 told her everything had improved, and everything was better. She said Resident #1 did not complain to her he was having symptoms of pain or discomfort. She said she had no concerns about his care at the facility. She said Resident #1 was afraid to do the in and out catheter self-care. She said he was not harmed at all by the situation of him getting catheterized approximately 2 hours late on 09/02/25 and she was not concerned at all about the nursing care treatment Resident #1 received at the facility. Interview on 09/13/25 at 5:35 pm with LVN A reflected Resident #1 had an in and out catheter and nursing staff had to assist him with his catheter. He said Resident #1 was care planned for a self-catheter, but the nurses had to make sure the catheter tubing went in the proper place. He said a nurse had to be there to guide the catheter tubing Interview on 10/02/2025 at