STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessments, for 5 (Residents #1, #2, #3, #4, and #5) of 6 residents reviewed for care plans, in that: Residents #1, #2, #3, #4, and #5's comprehensive care plans were not reviewed and revised after their quarterly MDS assessments were completed. These deficient practices could place residents at risk of current needs not being met. Findings included: Record review of Resident #1's Admission Record, dated 05/21/24, revealed Resident #1 was admitted to the facility on [DATE]. Resident #1 had diagnoses, which included: unspecified atherosclerosis (The build-up of fats, cholesterol, and other substances in and on the artery walls), unspecified severe protein-calorie malnutrition, morbid (severe) obesity due to excess calories, dementia (A group of thinking and social symptoms that interferes with daily functioning), and unspecified depression. Record review of Resident #1's Quarterly MDS Assessment, dated 04/17/24, revealed Resident #1 had a BIMS score of 3, which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's Care Plan Review History, dated 05/21/24, revealed Resident #1's comprehensive care plan was last reviewed and completed on 01/09/24. Record review of Resident #2's Admission Record, dated 05/23/24, revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses, which included: traumatic subdural hemorrhage without loss of consciousness (A type of traumatic brain injury), unsteadiness on feet, dementia, essential (primary) hypertension (A condition in which the force of the blood against the artery walls is too high), stage 1 pressure ulcer of sacral region (occur when a bony prominence, such as the sacrum, is subjected to prolonged pressure and can result in soft tissue injury), generalized muscle weakness, age-related osteoporosis (deterioration in bone mass and micro-architecture, with increasing risk to fragility fractures), unspecified lack of coordination, repeated falls, and cognitive communication deficit. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Quarterly MDS Assessment, dated 04/16/24, revealed Resident #2 had a BIMS score of 7, which indicated Resident #2 had severe cognitive impairment. Record review of Resident #2's Care Plan Review History, dated 05/23/24, revealed Resident #2's comprehensive care plan was last reviewed and completed on 01/08/24. Resident #2 also had a comprehensive care plan started on 03/24/24 that did not have a completion date, which indicated the comprehensive care plan was incomplete. Record review of Resident #3's Admission Record, dated 05/23/24, revealed Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses, which included: acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, major depressive disorder, muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), unspecified depression, legal blindness, essential hypertension, unsteadiness on feet, other lack of coordination, and presence of cardiac pacemaker. Record review of Resident #3's Comprehensive MDS Assessment, dated 04/19/24, revealed Resident #3 had a BIMS score of 15, which indicated Resident #3 was cognitively intact. Record review of Resident #3's Care Plan Review History, dated 05/23/24, revealed Resident #3's comprehensive care plan was last reviewed and completed on 11/29/23. Resident #3 also had a comprehensive care plan started on 02/26/24 that did not have a completion date, which indicated the comprehensive care plan was incomplete. Record review of Resident #4's Admission Record, dated 05/23/24, revealed Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses, which included: unspecified Alzheimer's disease (A progressive disease that destroys memory and other important mental functions), dementia, mild neurocognitive disorder (decreased mental function due to a medical disease other than a psychiatric illness), other recurrent depressive disorders, cognitive communication deficit, unsteadiness on feet, other lack of coordination, unspecified anxiety disorder, essential hypertension, unspecified chronic kidney disease, repeated falls, unspecified pain, and acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues in your body). Record review of Resident #4's Quarterly MDS Assessment, dated 03/08/24, revealed Resident #4 had a BIMS score of 15, which indicated Resident #4 was cognitively intact. Record review of Resident #4's Care Plan Review History, dated 05/23/24, revealed Resident #4's comprehensive care plan was last reviewed and completed on 12/30/23. Resident #4 also had a comprehensive care plan started on 02/27/24 that did not have a completion date, which indicated the comprehensive care plan was incomplete. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Admission Record, dated 05/23/24, revealed Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses, which included: cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), other lack of coordination, acquired absence of left leg above knee, non-pressure chronic ulcer of skin, unspecified dementia, acquired absence of right left below knee, mild protein-calorie malnutrition, muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), repeated falls, other reduced mobility, generalized muscle weakness, unsteadiness on feet, unspecified lack of coordination, and other symptoms and signs involving cognitive functions and awareness. Record review of Resident #5's Quarterly MDS Assessment, dated 04/30/24, revealed Resident #5 had a BIMS score of 9, which indicated Resident #5 was moderately impaired in her cognition. Record review of Resident #5's Care Plan Review History, dated 05/23/24, revealed Resident #5's comprehensive care plan was last reviewed and completed on 01/08/24. During an interview on 05/21/24 at 1:30 p.m., the ADM revealed the facility's Care Planning policy and procedure would be the closest document regarding when revision and timing for residents' MDS assessments and care plans needed to be completed. The ADM stated he was aware that some residents' care plans were overdue for a review and revision. The ADM did not state what the risk to residents were if residents' care plans were not reviewed and revised. The ADM stated the facility was working on the MDS assessment and care plan revision and timing issue. The ADM also stated the former MDS coordinator was terminated last year (December 2023) for not doing her job in completing MDS assessments and care plans. The ADM was not aware Residents #1, #2, #3, #4, and #5's care plans have not been reviewed and revised. The ADM stated the SW was reviewing and revising residents' care plans. The ADM did not know who appointed SW to review and revise care plans, when SW began the task, how he monitored to ensure care plans were reviewed and revised and how he was ensuring care plans were accurately completed other than discussing care plans during daily meetings in the morning and if the SW was trained on reviewing and revising residents' care plans . The ADM also stated the current MDS Coordinator (MDS Coordinator A) was part-time and only worked on completing residents' MDS assessments. The ADM stated he oversaw residents' MDS assessments and care plans to ensure timely completion. During an interview on 05/21/24 at 4:05 p.m., the SW revealed he had been helping with residents' care plans since 03/18/24 . The SW explained he arranged care plan meetings and reviewed and revised care plans. The SW further explained he was appointed by the previous company who owned the facility to review and revise care plans at the beginning of his employment. The SW stated he was not trained on how to review and revise residents' care plans . The SW explained he reached out to other facilities to learn how to review and revise care plans. The SW explained the ADM oversaw to ensure residents' care plans were reviewed and revised. The SW explained residents' care plans were reviewed and revised quarterly, annually, whenever there was a significant change in condition, and as needed. The SW did not know who was responsible for reviewing and revising residents' care plans. The SW explained reviewing and revising residents' care plans was not his responsibility and job duty and he performed the tasks because he took on more work and it was assigned to him. The SW stated he was the only staff member who worked on reviewing and completing residents' care plans. The SW stated MDS Coordinator A only worked on residents' MDS assessments, was PRN and did not communicate with him. The SW stated residents' health and safety could be affected if residents' care plans were not reviewed and revised within the required timeframes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/21/24 at 4:37 p.m., the DON revealed MDS Coordinator A telecommunicated. The DON explained MDS Coordinator A worked some days at home and some days at the facility. The DON stated the SW reviewed and revised residents' care plans. The DON did not know if SW was trained on reviewing and revising residents' care plans. The DON did not know who oversaw residents' care plans to ensure the care plans were completed within required timeframes. The DON stated residents' health and well-being could be affected if residents' care plans were not reviewed and revised. During an interview on 05/21/24 at 5:11 p.m., MDS Coordinator A revealed he worked part-time and had been helping with completing residents' MDS assessments during the weekends. MDS Coordinator A stated he was the only staff member who worked on completing residents' MDS assessments. MDS Coordinator A stated he was not responsible for reviewing and revising residents' comprehensive care plans. MDS Coordinator A stated the SW was scheduling residents' care plan meetings. MDS Coordinator A also stated the ADM oversaw to ensure residents' MDS assessments and care plans were completed. MDS Coordinator A stated residents' MDS assessments were reviewed and revised whenever resident had a significant change in condition and quarterly. MDS Coordinator A stated if there were 2 or more changes in residents' ADLs, then he would review and revise residents' MDS assessment because he considered residents' status to be a significant change. MDS Coordinator A also stated residents' health and safety could be affected if residents' care plans were not reviewed and completed. Record review of the facility's Care Planning policy and procedure, revised 10/24/22, revealed the following: The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive Admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments.