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	09/19/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, 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 two (Resident #1 and Resident #2) of five residents reviewed for quality of care. The facility failed to conduct a fall/skin assessment or conduct neuros consistently after unwitnessed falls for Residents #1 and #2. These deficient practices could place residents at risk of harm, injuries, or hospitalization . Findings included: Resident #1 Review of Resident #1's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including COPD (a chronic lung disease), morbid obesity, TBI, and a risk of falling. Review of Resident #1's quarterly MDS assessment, dated 07/17/24, reflected a BIMS of 8, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she had not experienced any falls since admission. Review of Resident #1's quarterly care plan, dated 09/03/24, reflected she was a moderate risk for falls related to gait/balance problems with an intervention of evaluation and treating as ordered or PRN. The care plan was not revised or updated to include additional interventions after she experienced falls on 08/21/24, 08/23/24, and 08/24/24. Review of Resident #1's progress notes, dated 08/21/24 at 8:28 PM and documented by LVN A , reflected the following: [Resident #1] noted lying on her right side in front her wheelchair I missed my bed while transferring myself I just sled [sic] off the chair I have no pain from the fallstated [sic] assessed for injuries none noted assisted to the bed . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Austin Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 11406 Rustic Rock Drive Austin, TX 78750	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's assessments in her EMR, on 09/04/24, reflected neither a skin/fall assessment were conducted after the fall on 08/21/24. Review of Resident #1's assessments in her EMR, on 09/04/24, reflected one neurological check was conducted after the fall on 08/21/24 at 7:23 PM. Review of Resident #1's progress notes, dated 08/23/24 at 3:22 PM and documented by RN B , reflected the following: [Resident #1] had an unwitnessed fall in her room. She denied hitting her head on the floor. Head to toe examination was done and no obvious injuries were noted . Review of Resident #1's assessments in her EMR, on 09/04/24, reflected neither a skin/fall assessment were conducted after the fall on 08/23/24. Review of Resident #1's assessments in her EMR, on 09/04/24, reflected one neurological check was conducted after the fall on 08/23/24 at 5:52 PM. Review of Resident #1's Fall Risk Evaluation, dated 08/23/24, reflected she was a high risk for falls. Review of Resident #1's progress notes, dated 08/24/24 at 7:34 AM and documented by LVN C , reflected the following: CNA called this nurse. This nurse entered room and found [Resident #1] lying on the bathroom floor in prone position. Put [Resident #1] back to wheelchair with 3 people assistant [sic]. [Resident #1] able to explain the situation. I was self-transferred [sic] to use toilet and fell . [Resident #1] complained pain on left hip and forehead 10 out of 10. [Resident #1] has a big bump on top of left eye. It's getting bigger. Sent to (hospital) . Review of Resident #1's progress notes, dated 08/24/24 at 1:32 PM and documented by LVN C, reflected the following: [Resident #1] came back with EMS stretcher. [Resident #1] companied [sic] of pain left hip and left side of forehead. Gave pain medication. CT scan is cleared . Review of Resident #1's ER discharge documentation, dated 08/24/24, reflected she was seen for a hematoma of scalp. Review of Resident #1's Fall Risk Evaluation, dated 08/24/24, reflected she was a moderate risk for falls. Review of Resident #1's progress notes, dated 09/02/24 at 9:37 AM and documented by LVN C, reflected the following: [Resident #1] was found on the floor at 8:20 AM, face down and bleeding from the forehead. [Resident #1] was unresponsive and without a pulse . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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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 - Some	Review of Resident #1's hospice note, dated 09/02/24, reflected the following: .ME contacted at 10:37 AM spoke with the investigator (name), gave ME all information on [Resident #1] and past falls that occurred. ME stated that they will be picking up the body d/t falls . [Resident #1]'s left eye is dark purple d/t fall last weekend. On 09/03/24 at 11:27 AM, all neurological checks for Resident #1 for the past month were requested from the ADM. During an interview on 09/03/24 at 12:00 PM, the ADM stated he was being told that there was only one neurological check conducted and had a copy of the one from 08/23/24. During an interview on 09/03/24 at 5:03 PM, the DON stated the last time she saw Resident #1 was on 08/30/24. She stated she remembered she had bruising from a fall by her left eye but could not remember the color. She stated it was the nurses' responsibility to document bruising in the residents' progress notes and skin assessments. The DON was asked if it met her expectations that the bruise was not documented and she stated, Well, it was fading . Resident #2 Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including mild intellectual disabilities, age-related physical debility, unsteadiness on feet, and other lack of coordination. Review of Resident #2's significant change in status MDS assessment, dated 07/26/24, reflected a BIMS of 12, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she had experienced a fall since admission that resulted in a major injury. Review of Resident #2's quarterly care plan, dated 06/12/24, reflected she had an actual fall with an intervention of checking range of motion daily. The care plan was not revised or updated to include additional interventions after she experienced falls on 06/14/24, 07/21/24, and 07/27/24. Review of Resident #2's progress notes, dated 06/14/24 at 7:17 PM and documented by LVN B , reflected the following: [Resident #2] was transferred to the hospital post fall. The documentation did not reflect what/how the fall occurred. Review of Resident #2's assessments in her EMR, on 09/04/24, reflected neither a skin/fall assessment were conducted after the fall on 06/14/24. Review of Resident #2's assessments in her EMR, on 09/04/24, reflected six neurological checks were conducted; 06/14/24 at 10:14 PM and 06/15/24 at 6:27 AM, 6:34 AM, 6:42 AM, 1:24 PM, and 11:37 PM. Review of Resident #2's ER documentation, dated 06/14/24, reflected the primary impression was a scalp contusion. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's progress notes, dated 06/19/24 at 12:44 PM and documented by the DON, reflected the following: [Resident #2] was sent to the hospital for further evaluation . There was no documentation reflecting why further evaluation was needed. Review of Resident #2's progress notes, dated 07/21/24 at 1:25 PM and documented by LVN E , reflected the following: . [Resident #2] was found kneeling on the floor, using her hands to hold the upper body up. She was morning [sic] in pain, while bleeding from the back of her head . 911 was called . Review of Resident #2's assessments in her EMR, on 09/04/24, reflected neither a skin/fall assessment were conducted after the fall on 07/21/24. Review of Resident #2's assessments in her EMR, on 09/04/24, reflected one neurological check was conducted on 07/21/24 12:00 PM. Review of Resident #2's progress notes, dated 07/27/24 at 12:39 AM and documented by LVN A, reflected the following: [Resident #2] returned from (hospital) . [Resident #2] has dx of L1 fracture and well as seventh left side rib fracture . Review of Resident #2's progress notes, dated 07/27/24 at 5:14 PM and documented by LVN B, reflected the following: [Resident #2] fell in the hallway while using her walker to ambulate . Review of Resident #2's progress notes, dated 07/30/24 at 9:34 AM and documented by LVN B, reflected the following: . history of falls. Intervention for frequent falls will include use of helmet as an intervention. The helmet was not listed as an intervention in her care plan, nor was there a physician order for a helmet. Review of Resident #2's assessments in her EMR, on 09/04/24, reflected neither a skin/fall assessment were conducted after the fall on 07/27/24. During an interview on 09/03/24 at 12:50 PM, LVN F stated if a resident had an unwitnessed fall, a head-to-toe assessment would need to be conducted. She stated she would document the fall and conduct neuros every 15 minutes X4, every 30 minutes X4, and so on for 72 hours. She stated neuro checks were documented in the residents' EMR, not on paper. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/03/24 at 2:37 PM, the DON stated after a resident has a fall the nurse is to complete an assessment. She stated after the assessment is complete, if there was no injury, the nurse would get the resident up. She stated the nurse then had to monitor the resident for three days. She stated if it was an unwitnessed fall you had to treat it as a head injury so neuro checks would need to be documented for 72 hours, a fall assessment would need to be completed, and one more thing, but I cannot remember what it was. She stated she was responsible for ensuring neuro checks were done and to complete any missing items. She stated it would not meet her expectations if neuro checks were not documented after a fall and maybe the nurses did them on paper - I am sure it is there. During an interview on 09/03/24 at 2:44 PM, LVN G stated neuro checks and fall assessments were documented in the residents' EMR, not on paper. During an interview on 09/03/24 at 2:50 PM, RN H stated neuro checks and fall assessments were documented in the residents' EMR, not on paper. During an interview on 09/03/24 at 4:17 PM, the ADM stated if an aide found a resident on the ground, they should notify the nurse immediately who would conduct a fall assessment and beigin doing neuros. He stated all falls were discussed in the morning meetings and the DON was responsible for ensuring all assessments were being completed. He stated a negative outcome of not completing all proper assessments could be that an injury could go missed, or if they hit their head, they could have a brain bleed . During an interview on 09/03/24 at 4:52 PM, the DON stated she started an in-service (that day) on neurological checks being documented on an observation sheet (paper). She stated she started the in-service because she could not find the missing neuro checks in the computer for Resident #1 and #2. During a telephone interview on 09/04/24 at 9:39 AM, Resident #1 and #2's MD stated he was notified of their increase in falls. He stated if a resident had an unwitnessed fall or hit their head, he would expect neurological checks to be conducted for 72 hours to ensure there was not a change in condition. He stated he would have expected the facility to have put new interventions in place when the falls increased. Review of the in-service entitled Falls, dated 09/03/24, reflected the following: Neurological checks must be done on all falls, witnessed and unwitnessed falls. Neuro checks will be done: Q 15 minutes X 4 Q 30 minutes X 4 One hour X 4 Every 8 hours until completion of 72 hours (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Fall Evaluation and Prevention Policy, revised 08/2020, reflected the following: Purpose: To ensure that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance to prevent accidents. The facility will evaluate residents for their fall risk and develop interventions for prevention . The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. Following a fall, the following steps should be undertaken: -Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. The evaluation should include vital signs and neurological status. - If there was a loss of consciousness or the fall was unwitnessed, neuro signs should be initiated and checked for at least 72 hours. - Following the resident's evaluation, transfer the resident to the appropriate surface and evaluate further if indicated. Monitor closely for indications of pain or discomfort in any area, reddened or discolored areas, or other signs of injury.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42949

Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for two (Resident #1 and Resident #2) of five residents reviewed for accidents and hazards.

The facility failed to:

- Address or put in place new interventions when Residents #1 and #2 had a change-in-condition and began experiencing more frequent falls in a short time-frame.

- Implement the new intervention of a helmet that was documented in a nursing noted for Resident #2 after a fall on 07/27/24.

These failures resulted in an identification of an Immediate Jeopardy (IJ) on 09/18/24 at 9:15 AM. While the IJ was removed on 09/19/24 at 3:55 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

These deficient practices could place residents at risk of harm, injuries, or hospitalization .

Findings included:

Resident #1

Review of Resident #1's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including COPD (a chronic lung disease), morbid obesity, TBI, and a risk of falling.

Review of Resident #1's quarterly MDS assessment, dated 07/17/24, reflected a BIMS of 8, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she had not experienced any falls since admission.

Review of Resident #1's quarterly care plan, dated 09/03/24, reflected she was a moderate risk for falls related to gait/balance problems with an intervention of evaluation and treating as ordered or PRN. The care plan was not revised or updated to include additional interventions after she experienced falls on 08/21/24, 08/23/24, and 08/24/24.

Review of Resident #1's progress notes, dated 08/21/24 at 8:28 PM and documented by LVN A , reflected the following:

[Resident #1] noted lying on her right side in front her wheelchair I missed my bed while transferring myself I just sled [sic] off the chair I have no pain from the fallstated [sic] assessed for injuries none noted assisted to the bed .

(continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/03/24 at 12:50 PM, LVN F stated if a resident had an unwitnessed fall, a head-to-toe assessment would need to be conducted. She stated she would document the fall and conduct neuros every 15 minutes X4, every 30 minutes X4, and so on for 72 hours. She stated neuro checks were documented in the residents' EMR, not on paper. LVN F stated she did not believe Resident #2 had a helmet as she had never seen her wearing one. During an interview on 09/03/24 at 2:37 PM, the DON stated after a resident has a fall the nurse is to complete an assessment. She stated after the assessment is complete, if there was no injury, the nurse would get the resident up. She stated the nurse then had to monitor the resident for three days. She stated if it was an unwitnessed fall you had to treat it as a head injury so neuro checks would need to be documented for 72 hours, a fall assessment would need to be completed, and one more thing, but I cannot remember what it was. She stated she was responsible for ensuring neuro checks were done and to complete any missing items. She stated it would not meet her expectations if neuro checks were not documented after a fall and maybe the nurses did them on paper - I am sure it is there. When asked why fall risk assessments were not completed accurately, why new interventions were not put into place when both Residents #1 and #2 began experiencing more frequent falls in a short time period, and why Resident #2's helmet intervention was never implemented, the DON just shook her head and said it probably all happened before she started working at the facility. She stated resident falls were discussed in the morning meetings and if need be, the IDT would get together to discuss new interventions for safety, but could not answer why this was not done for Residents #1 and #2. During an interview on 09/03/24 at 2:44 PM, LVN G stated neuro checks and fall assessments were documented in the residents' EMR, not on paper. During an interview on 09/03/24 at 2:50 PM, RN H stated neuro checks and fall assessments were documented in the residents' EMR, not on paper. During an interview on 09/03/24 at 4:17 PM, the ADM stated if an aide found a resident on the ground, they should notify the nurse immediately who would conduct a fall assessment and beigin doing neuros. He stated all falls were discussed in the morning meetings and the DON was responsible for ensuring all assessments were being completed. He stated a negative outcome of not completing all proper assessments could be that an injury could go missed, or if they hit their head, they could have a brain bleed. During an interview on 09/03/24 at 4:52 PM, the DON stated she started an in-service (that day) on neurological checks being documented on an observation sheet (paper). She stated she started the in-service because she could not find the missing neuro checks in the computer for Resident #1 and #2. During a telephone interview on 09/04/24 at 9:39 AM, Resident #1 and #2's MD stated he was notified of their increase in falls. He stated if a resident had an unwitnessed fall or hit their head, he would expect neurological checks to be conducted for 72 hours to ensure there was not a change in condition. He stated he would have expected the facility to have put new interventions in place when the falls increased. Review of the in-service entitled Falls, dated 09/03/24, reflected the following: Neurological checks must be done on all falls, witnessed and unwitnessed falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Austin Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Neuro checks will be done: Q 15 minutes X 4 Q 30 minutes X 4 One hour X 4 Every 8 hours until completion of 72 hours Review of the facility's Fall Evaluation and Prevention Policy, revised 08/2020, reflected the following: Purpose: To ensure that the resident's environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance to prevent accidents. The facility will evaluate residents for their fall risk and develop interventions for prevention . The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. Following a fall, the following steps should be undertaken: -Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. The evaluation should include vital signs and neurological status. - If there was a loss of consciousness or the fall was unwitnessed, neuro signs should be initiated and checked for at least 72 hours. - Following the resident's evaluation, transfer the resident to the appropriate surface and evaluate further if indicated. Monitor closely for indications of pain or discomfort in any area, reddened or discolored areas, or other signs of injury. The ADM and DON were notified on 09/18/24 at 9:15 AM that an IJ had been identified and an IJ template was provided. The following POR was approved on 09/19/24 at 7:40 AM: The notification of Immediate Jeopardy states as follows: F689 -The facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision. Action: DON and ADON in-serviced by CNO on Inservice on Fall Documentation and interventions, Assessments and interventions, on Fall policy and procedure, and on Abuse and Neglect. Start Date: 9/18/24 Completion Date: 9/18/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Austin Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 11406 Rustic Rock Drive Austin, TX 78750	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Responsible CNO Action: In-service on Fall policy and procedure implemented to all nursing staff- Ongoing until 100% completion. All Nursing Staff will complete in-service prior to starting their next shift. Start Date: 9/18/2024 Completion Date: 9/18/2024 (any nursing staff not completed the in-service, will not be permitted to work a shift until in-service has been completed.) Responsible: DON, ADON , Administrator Action: Inservice on Abuse and Neglect implemented to all staff, ongoing until 100% completion. Staff will complete in-service prior to starting their next shift. Start Date: 9/18/2024 Completion Date: 9/18/2024 (any staff not completed the in-service, will not be permitted to work a shift until in-service has been completed.) Responsible DON, ADON, Administrator Action: Inservice on Fall Documentation, Assessments, and fall intervention, has been implemented with all Nurses, Ongoing until 100% completion. Staff will complete in-service prior to starting their next shift. Start Date: 9/18/2024 Completion Date: 9/18/2024 (any Nurse not completed the in-service, will not be permitted to work a shift until in-service has been completed.) Responsible DON, ADON, Administrator Action: Audit all resident with fall risk to ensure interventions are in place and documented Start Date: 9/18/2024 Completion Date: 9/18/2024 Responsible DON, ADON, MDS, Administrator Action: ADHOC Qapi meeting conducted by IDT Team on fall events. Attending staff Admin, DON, ADON, SW, DOR, Activities Director will attend. Start Date: 9/18/2024 Completion Date: 9/18/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Austin Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 11406 Rustic Rock Drive Austin, TX 78750	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Responsible Administrator, DON, ADON, SW, DOR, Activities Director. The Surveyor monitored the POR on 09/19/24 as followed: During interviews on 09/19/24 from 11:56 AM - 3:20 PM, staff from all shifts were interviewed (one RN, four LVNs, four CNAs, and two MAs). The CNAs and MAs all stated they were in-serviced before their shifts on abuse and neglect and the facility's fall policy. They all stated if they witnessed a resident on the floor, they would press the call light or call for a nurse so they could be assessed. They stated they would not move the resident nor would they leave the resident alone. The nurses all stated they were in-serviced before their shifts on abuse and neglect and falls. They all stated if a resident fell , they would immediately assess them with a head-to-toe assessment and ensure they were not bleeding. They would conduct a fall assessment, fall risk assessment, and start neurological checks if they hit their head or if the fall was unwitnessed. They all stated that neurological checks needed to be documented and continued for 72 hours. They all stated neuro checks popped up in the EMR when the next one was due. They stated the importance of documentation was to ensure all assessments had been completed and all of the nursing staff were aware of the fall. They stated if a resident began having more frequent falls, it was important to put further interventions in place to attempt to lessen the number of falls. During an interview on 09/19/24 at 3:06 PM, the DON stated she, the ADON, and ADM received training by their CNO. She stated fall risk assessments should be done on admission, quarterly, and after a fall. She stated neuro checks were to be done every 15 minutes x4, every 30 minutes x4, every hour for 24 hours, and completed after 72 hours. She stated she was completing daily audits after resident falls of nursing documentation of neuro checks, fall assessments, and fall risk assessments. Review of the facility's QAPI Meeting Agenda, dated 09/18/24, reflected the ADM, DON, ADON, SW, DOR, AD, and MD were in attendance. Review of an in-service, dated 09/18/24 and conducted by the CNO, reflected the ADM, DON, and ADON were in-serviced on the Fall Management Policy and Procedure. Review of an in-service, dated from 09/18/24 - 09/19/24 and conducted by the DON, reflected all staff were in-serviced on abuse and neglect. Review of an in-service, dated from 09/18/24 - 09/19/24 and conducted by the DON, reflected all nursing staff were in-serviced on frequent rounding, documentation of falls, conducting neuros, and fall and skin assessments, and their fall policy. Review of nine residents' EMRs that experienced a fall in September 2024, on 09/19/24, reflected updated care plans, a fall assessment, a fall risk assessment, and neuro checks as needed. While the IJ was removed on 09/19/24 at 3:55 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455799	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42949

Based on interview and record review, the facility failed to ensure that medical records were accurately documented for one (Resident #3) of five residents reviewed for accurate medical records.

The facility failed to ensure Resident #3's medical chart contained any documented nursing progress notes.

This deficient practice could result in errors in care and treatment.

Findings included:

Review of Resident #3's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that causes memory loss), hypertension (high blood pressure), seizures, and type II diabetes.

Review of Resident #3's quarterly MDS assessment, dated 08/15/24, reflected a BIMS of 6, indicating a severe cognitive impairment.

Review of Resident #3's quarterly care plan, dated 05/30/24, reflected she had an ADL self-care performance deficit with an intervention of requiring staff supervision with transfers and bed mobility. It further reflected she was a moderate risk for falls related to gait/balance problems with an intervention of anticipating/meeting her needs.

Review of Resident #3's progress notes section in her EMR, on 09/04/24, reflected no documentation since her admission.

During an interview on 09/04/24 at 11:42 AM, the DON stated her expectations were that nurses document everything that was going on with the resident in their charts such as incidents, new orders, and the progress of the resident. She stated for a resident to not have any progress notes for four months would be unacceptable. She stated documentation was important so all nurses could see any changes in residents or any new interventions. She stated if it was not documented, it did not happen.

Review of the facility's Nursing Documentation Policy, revised 06/2020, reflected the following:

Nursing documentation will be concise, clear, pertinent, accurate, and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures.

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K. Documentation will be completed by the end of the assigned shift.