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	09/27/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interview and record review, the facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for three (Residents #1, #2 and #3) of seven residents reviewed for baseline care plans. The facility failed to develop baseline care plans for Resident #1, #2, and #3. This deficient practice could place residents at risk of not having individualized needs met, a delay in services, sustaining injuries, and not receiving adequate care. Findings included: Resident #1 Review of Resident #1's admission record, dated 09/27/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury), cocaine abuse with cocaine-induced anxiety disorder, chronic viral hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), other recurrent depressive disorders, unspecified post-traumatic stress disorder, bipolar type schizoaffective disorder, unspecified fracture of left patella (kneecap), and unspecified protein-calorie malnutrition. Review of Resident #1's BIMS assessment, dated 09/25/24, reflected she had an 8 BIMS score, which indicated she had moderate cognitive impairment. Review of Resident #1's assessment log, dated 09/27/24, reflected her baseline care plan was initiated on 09/22/24, incomplete, and overdue. Resident #2 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's admission record, dated 09/27/24, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a serious neurological disorder that occurs when a chemical imbalance in the blood affects the brain), acute cystitis without hematuria (a bladder infection that develops suddenly), type 2 diabetes mellitus, unspecified hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood), and unspecified depression. Review of Resident #2's BIMS assessment, dated 09/18/24, reflected she had an 8 BIMS score, which indicated she had moderate cognitive impairment. Review of Resident #2's assessment log, dated 09/27/24, reflected she had no baseline care plan. Review of Resident #2's care plan log, dated 09/27/24, reflected her comprehensive care plan was initiated on 09/17/24 and incomplete. Resident #3 Review of Resident #3's admission record, dated 09/27/24, reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, essential hypertension, unspecified hyperlipidemia, and age-related cognitive decline. Review of Resident #3's BIMS assessment, dated 09/27/24, reflected he had a 12 BIMS score, which indicated he had moderate cognitive impairment. Review of Resident #3's assessment log, dated 09/27/24, reflected he had no baseline care plan. Review of Resident #3's care plan log, dated 09/27/24, reflected his comprehensive care plan was initiated on 09/24/24 and incomplete. During an interview on 09/27/24 at 12:13 p.m., the ADM stated residents' baseline care plans were supposed to be completed on residents' admitted s. During an interview on 09/27/24 at 1:23 p.m., the ADON stated residents' baseline care plans were completed by a combination of nurses and the MDS Coordinator. The ADON stated she expected residents' baseline care plans to be completed within a week of admission. The ADON stated residents' health could be affected if their baseline care plans and comprehensive care plans were not completed. The ADON stated there was no one overseeing the timely completion of residents' baseline care plans, but she believed it would be the MDS Coordinator who oversaw the process. The ADON stated she was aware that there were incomplete resident baseline care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 1:37 p.m., the MDS Coordinator stated he helped the facility with completing MDS assessments. MDS Coordinator stated he did not help with completing residents' baseline care plans. MDS Coordinator explained the nurses completed residents' baseline care plans within 24-72 hours of admission. MDS Coordinator stated he completed residents' comprehensive care plans between 7-14 days of admission unless there was no baseline care plan completed, at which point he would complete it right away. MDS Coordinator stated he had not checked to see if there were any residents who needed baseline care plans completed. MDS Coordinator stated he did not oversee to ensure residents' baseline care plans were completed. MDS Coordinator stated he assumed the ADON or DON oversaw to ensure residents' baseline care plans and comprehensive care plans were completed. MDS Coordinator stated residents' health could be affected if no baseline or comprehensive care plan was completed because staff must know residents' ability to perform ADLs. Review of the facility's care planning policy and procedure reflected the following: The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. The Facility may choose to develop a Comprehensive Care Plan in place of the Baseline Care Plan if the Comprehensive Care Plan is completed within 48 hours of admission.

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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	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** 47065 Based on interviews and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident for one (Resident #1) of seven residents reviewed for medication administration. The facility failed to ensure Resident #1 was administered her prescribed Ertapenem Sodium Injection Solution (used to treat certain serious infections). This deficient practice could place residents at risk of not being provided their routine and emergency drugs and biologicals to meet their needs, infection, or having medical conditions worsen or be exacerbated. Findings included: Review of Resident #1's admission record, dated 09/27/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury). Review of Resident #1's BIMS assessment, dated 09/25/24, reflected she had an 8 BIMS score, which indicated she had moderate cognitive impairment. Review of Resident #1's assessment log reflected her baseline care plan was initiated on 09/22/24, incomplete, and overdue. Review of Resident #1's care plan log reflected her comprehensive care plan was initiated on 09/20/24 and incomplete. Review of Resident #1's orders reflected the following: -Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenously one time a day for central IV access related to sepsis, unspecified organism until 10/17/24 11:59 p.m. four week IV ABT therapy. The verbal order was active, ordered and started on 09/21/24 and ended on 10/17/24. Review of Resident #1's MAR for September 2024 reflected no documented medication administration entry for Resident #1's Ertapenem Sodium Injection Solution Reconstituted on 09/22/24. Review of Resident #1's progress notes, from 09/21/24 through 09/23/24, reflected no explanatory notes related to the undocumented medication administration entry in the MAR on 09/22/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a group interview on 09/27/24 at 9:35 a.m., the ADON stated Resident #1 was taking antibiotic medication. The ADON stated Resident #1 received her antibiotic medication once a day per her order. The ADON stated Resident #1 was a little confused. The ADM stated Resident #1 was admitted to the facility last Friday (09/20/24). The ADM stated Resident #1 thought she was not receiving her antibiotic medication. During an interview on 09/27/24 at 10:11 a.m., Resident #1 stated she got an infection a month prior to her admission. Resident #1 stated she did not get her antibiotic medication for three days. Resident #1 stated she received her antibiotic once daily. Resident #1 stated she was supposed to receive her antibiotic once daily. During an interview on 09/27/24 at 10:43 a.m., CE A stated Resident #1 was taking IV antibiotic medication once a day. CE A stated Resident #1 received her antibiotic medication daily. CE A stated staff documented medication administrations in residents' MARs. During an interview on 09/27/24 at 11:00 a.m., CNA B stated Resident #1 asked for her antibiotic medication at times. CNA B stated she notified the nurse whenever Resident #1 asked for her antibiotic medication. CNA B stated medication aides and nurses administered antibiotic medications to residents. During an interview on 09/27/24 at 11:09 a.m., CMA C stated nurses administered antibiotic IV medications to residents. During an interview on 09/27/24 at 12:20 p.m., CE D stated Resident #1 told them that she had to ask the nurses to give her antibiotic medication. During an interview on 09/27/24 at 1:23 p.m., the ADON stated nurses documented residents' medication administrations in residents' MARs and medication aides documented residents' medication administrations in residents' EMARs. ADON stated if nurses did not document residents' medication administrations, then the medication administration was not completed. ADON stated she tried to review residents' MARs once weekly. ADON stated the pharmacist audited and told her that there were missed medication administration record entries. ADON stated she expected staff to document residents' medication administrations. During an interview on 09/27/24 at 1:37 p.m., the MDS Coordinator stated nurses documented residents' medication administrations in residents' MARs. The MDS Coordinator stated residents' health could be affected if nurses did not document residents' medication administrations in residents' MARs. The MDS Coordinator explained if residents' medication administrations were not documented, then it must be assumed that the medication was not administered to the residents. Review of the facility's general guidelines for medication administration policy and procedure, revised 08/2020, reflected the following: Administration: 2. Medications are administered in accordance with written orders of the prescriber. Documentation: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. 4. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross-referenced to a full signature in the space provided. 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a starter dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses, or in accordance with facility policy, or a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response.