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	11/24/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to develop and implement a person-centered comprehensive care plan to meet the preferences and goals of each resident and address the resident's medical, physical, mental and psychosocial needs for one (Resident #1) of three residents reviewed for care plan. The facility failed to develop Resident #1's comprehensive care plan to address all Resident #1's care needs. Resident #1's comprehensive care plan did not address the need for pain medication / management, risks for pressure ulcer development, assistance needed for ADL care, incontinence to bowel and bladder, medications Resident #1 was taking to manage disease processes, Hospice care, reason for oxygen therapy, DNR status, fall risk, elopement risks. This deficient practice could place residents at risk for not receiving necessary care and services. Findings included:Review of Resident #1's face sheet printed [DATE] reflected a [AGE] year-old male who was admitted on [DATE]and readmission of [DATE] with the following dx: Chronic Obstructive Pulmonary Disease (is a condition caused by damage to the airways or other parts of the lung), Type 2 Diabetes Mellitus without complication (happens when the body cannot use insulin correctly and sugar builds up in the blood) , Pneumonia (an infection in one or both of your lungs. It causes the air sacs of your lungs to fill up with fluids and pus), Essential (Primary) Hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause), bipolar disorder (is a mental health condition that causes extreme mood swings), Depression (also known as Depressive Disorder, is a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time. It is different from regular mood changes), chronic kidney disease (is characterized by the presence of kidney damage. It is a stat of progressive loss of kidney function), Benign Prostatic Hyperplasia without lower Urinary Tract Symptoms (refers to the non-malignant growth or hyperplasia of prostate tissue and a common cause of lower urinary tract symptoms in older men), Low back pain, Jaw pain, Age related decline, Asthma (a chronic lung disease affecting people of all ages. It is caused by inflammation and muscle tightening around the airway which makes it harder to breathe.). Review of Resident#1's Significant change MDS assessment dated [DATE] reflected a BIMS score of 11, indicating moderate cognitive impairment. *Section H-Bladder and Bowel reflected Resident #1 was occasionally incontinent to bladder and frequently incontinent to bowels. *Section I- Active Diagnoses reflected the following diagnoses: Bipolar Disorder, Depression, Respiratory failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus without complication, Pneumonia, Essential (Primary) Hypertension, chronic kidney disease, Benign Prostatic Hyperplasia without lower Urinary Tract Symptoms, Low back pain, Jaw pain, Age related decline. *Section J-Health Conditions reflected Resident #1 received scheduled pain medication and PRN pain medication. Section-J also reflected Resident #1 pain frequency was frequently at a numeric rating of 7 on the scale 0-10 with 10 being the highest. *Section-M-Skin Condition reflected Resident #1 was at risk of developing pressure ulcers and pressure reducing device for bed was needed. *Section N-Medication reflected Resident #1 was taking the following medication: antipsychotic, antianxiety, antidepressant, opioid, antiplatelet, anticonvulsant. *Section O-Special Treatments reflected Resident #1 was on oxygen therapy and on Hospice care. Review of Resident #1's comprehensive care plan initiated [DATE] reflected only 2 care areas were addressed: The resident has Pneumonia. Azithromycin ordered and the resident has a behavior problem r/t smoking while oxygen is flowing. Further review revealed Resident #1's comprehensive care plan did not address the need for: *pain medication / management, *risks for pressure ulcer development, *assistance needed for ADL care, *incontinence to bowel and bladder,* medications Resident #1 was taking to manage disease processes, *Hospice care, *reason for oxygen therapy, *DNR status, *fall risk, and *elopement risks. Review of Resident #1's clinical assessments reflected the following:*Fall Risks evaluation completed [DATE] reflected a score of 15 indicating high fall risk.*Elopement Risks evaluation completed [DATE] reflected a score of 9 indicating imminent risk for elopement. Review of Resident #1's physician orders reflected the following orders: *Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 vial inhale orally every 6 hours for wheezing, shortness of breath given while awake dated [DATE].*DILTIAZEM 24HR ER (CD) 240MG CAP ER 24H Give 1 tablet by mouth one time a day for blood pressure dated [DATE] *Flomax Capsule 0.4 MG (Tamsulosin HCl) Give 2 capsules by mouth one time a day for benign prostatic hyperplasia dated [DATE].*Mirtazapine Tablet 7.5 MG Give 7.5 mg by mouth at bedtime for appetite dated [DATE] *Montelukast Sodium Tablet 10 MG Give 10 mg by mouth in the