| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455799 | A. Building<br>B. Wing | 01/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Austin Wellness & Rehabilitation | 11406 Rustic Rock Drive<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a complete care plan that meets all of a resident's needs, with timeframes and actions that can be measured for 1 of 8 residents (Resident #1) reviewed for care plan. The facility failed to develop Resident #1's care plan to reflect refusals of showers and interventions which included skin assessment and reduction of risk for skin breakdown. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs.Findings include: During an interview with the DON on 01/10/2026 at 10:48 a.m., she said she was trained on completing care plans. She said the residents' participation in ADLs and if they refused care, this information should go on the care plan. She said the care plan should be updated and she did not know why Resident #1's care plan was not updated. She said if something was not on the care plan it could affect the quality of care for the residents. She said the DON, ADON and the social worker were responsible to ensure the care plan was updated continuously when new problem care area was identified. She said it was monitored through IDT care plan meetings. She said she did not know why Resident #1's care plan did not have risk/goals/interventions for her refused care including showers and changing briefs. She stated that not updating her care plan could increase Resident #1's risk for skin breakdown and infection (UTI). During an interview with the ADM on 01/10/2026 at 12:44 p.m., he said he was trained on residents' care plans. He said the training covered the overall protocol for the care plan. He said the care plan should be person centered. He said if a resident refused services often then it should be in the care plan so staff would know she refused. He said the facility had an IDT team that put information in the care plan. He said the care plan if not revised could cause the residents to have inadequate care. He said the DON monitored to ensure the care plan was correct. The ADM said he did not know how the DON monitored the revision of care plans. He said he had asked the DON at the time to care plan Resident #1's care refusals back in September 2025 and he did not care plan it himself. Record review of Resident #1's face sheet, dated 1/09/2026, revealed an 80-years-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Cerebral infarction (the death of brain tissue [infarct] due to a blocked artery, cutting off oxygen and nutrients, typically from a blood clot), chronic pain, depression (a serious mood disorder causing persistent sadness and loss of interest, affecting how you feel, think, and behave, interfering with daily life), morbid obesity (a severe form of obesity defined by a Body Mass Index [BMI] of 40 or higher), altered mental status (a general term for a sudden change in brain function, causing confusion, disorientation, decreased alertness, or unusual behavior), hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body, often affecting an arm, leg, or face, resulting from brain damage) following cerebral infarction affecting right dominant side. Record review of Resident #1's comprehensive care plan reflected it consisted of the last revisions to Resident #1's ADL self-care performance goals, dated<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/30/2023, which did not include her refusal of care. Record review of the facility's Care Planning Policy, dated 10/24/2023, revealed the purpose of care planning is to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will need to be reflected on updated Care Plan. Record review of Resident #1's nursing progress notes, dated 11/26/2025, 11/20/2025, 11/19/2025, 11/14/2025, 11/13/2025, 11/11/2025, 10/15/2025 and, 10/3/2025, revealed Resident #1 refused to be changed and take showers from nurses and CNAs. Resident #1 has incontinence urine, chronic refusal of ADLs, and getting out of bed. Record review Psychiatric subsequent assessment, dated 05/07/2025, revealed the collateral information: Staff say patient has a hx of refusing care and often isolates to her room. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 7, which indicated severe cognitive impairment. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed make sure that drugs are stored properly and only authorized persons have access for 1 of 3 medication carts (MC #1) reviewed for drug storage and labeling. The facility failed to ensure MC #1 was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included: During an Observation of the nurses station on 01/10/2026 at 07:39a.m., revealed MC#1 was unlocked and unattended. RN A was sitting inside the nurses station out of view of the medication cart. Another RN walked past MC #1 and went into the nurses station and did not lock MC #1. Residents were walking by the unlocked medication cart. MC #1 contained residents prescribed creams, residents prescribed drugs, over the counter medication, narcotics, and injectable antibiotics. During an interview with RN A on 01/10/2026 at 07:43a.m., revealed that she had been trained on medication storage. She said the medication cart policy was the medication cart was to be locked any time staff stepped away from it. She said that the nurse was responsible for locking the medication cart. She said if the medication cart was left unlocked and unattended a resident might get into the medication. She said all staff monitored to ensure the medication carts were locked. She said staff monitored by locking the medication cart if they saw the cart unlocked. She said she was told state was in the building, so she walked around the nurses station to grab something. She said she did not see the surveyor open the drawers and take pictures. During an interview with the DON on 01/10/2026 at 10:48a.m., revealed she had been trained on medication storage. She said the medication cart policy was that the medication cart must be locked when not in use or the nurse was not around the cart. She said the medication aide and the nurses who passed the medication were responsible for locking the carts. She said if the cart was left unlocked the residents could get into the cart and take medications that are not prescribed to them. She said the DON monitors to ensure the cart were locked, She said the DON monitored through observations. She said if she saw a medication cart unlocked she would tell the staff to lock the medication cart and start an in-service. She said she did not know why RN A left her cart unlocked. During an interview with the ADM on 01/10/2026 at 12:44p.m., he was not clinical, but his expectation was for staff to lock the medication cart. He said the medication cart must be locked when staff were not using the medication cart. He said the person who was on the cart was responsible for locking the cart, but any staff can lock it. He said if the medication cart was left unlocked and unattended it could cause a drug diversion, or a resident could get into the medication cart. He said all staff monitored to ensure the medication carts were locked. He said if staff saw a medication cart unlocked the staff member should lock the cart. He said he did not know why RN A left her medication cart unlocked. Record review of Storage and Expiration Dating of Medications and Biologicals Policy dated 6/30/2025, revealed Facility should ensure that only authorized facility staff, as defined by facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with applicable law. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. |