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	03/20/2026

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident #1) reviewed for care plan revisions.The facility failed to ensure that Resident #1's care plan was comprehensive and complete, reflecting his complex active medical conditions.This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #1's face sheet dated 03/20/26 revealed a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Coronary Artery Disease (Limited blood flow in the arteries of the heart) , End-Stage Renal Disease (kidney failure), Heart Failure, Hypertension, Diabetes Mellitus , Peripheral Vascular Disease(blood circulation issues), Gastroesophageal Reflux Disease(acid reflux), Pneumonia, Chronic Obstructive Pulmonary Disease (breathing difficulty) , Hyperlipidemia (high cholesterol), Depression, Post Traumatic Stress Disorder (a mental disorder) , Anemia(tiredness) and Pain.Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating the cognition of the resident was intact. Further review of the MDS reflected that Resident #1 was actively diagnosed with medically complex conditions. They were Coronary Artery Disease, End-Stage Renal Disease, Heart Failure, Hypertension, Diabetes Mellitus, Peripheral Vascular Disease(blood circulation issues), Gastroesophageal Reflux Disease, Pneumonia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Depression, Post Traumatic Stress Disorder, Anemia and Pain.Record review of Resident #1's March 2026 MAR revealed resident was receiving medications for all his complex medical conditions.Record review of Resident #1's comprehensive care plan, initiated on 03/05/26, revealed that there were no care plans for any of his active complex medical conditions.During an interview on 03/20/26 at 10:20am Resident #1 stated he was not happy with the nursing he received at the facility. He stated that he and his family member are in the process of looking for a better facility. Resident #1 said the staff at the facility were not doing their job properly . He mentioned that he received his medications sometimes not on time. He also said that recently he missed his watch and suspects that one of the staff members took it. Overall, he said his experience at the facility was not good.During a phone interview on 03/20/26 at 11:30am , the MDSC stated that he was responsible for initiating, updating, and completing care plans. He indicated that he was aware of the timing parameters for completing care plans. The MDSC also mentioned that he received information about residents' medical conditions or changes during the daily IDT meetings and made updates accordingly. He said he was under the impression that he had completed the care plan for Resident #1 following the completion of his MDS assessment on 02/05/26. The MDSC stated that care plans were an integral part of nursing care, providing relevant information about residents and their conditions, as well as appropriate interventions to address them.On 03/20/26 at 12:45pm , RN A stated she worked at the facility as a PRN nurse. She reported that she uses the Kardex (a concise summary of essential (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	03/20/2026

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 - Few	patient information and daily care needs, updated each shift) for resident care. RN A added that she had not referred to care plans ever, as the Kardex was available at the facility. When asked about the importance of care plans, she stated she was not aware of their relevance. RN A also mentioned that she had never received any in-service training on care plans.On 03/20/26 at 2:30 p.m., RN B stated she had been employed at the facility since December 26 and had not referred to care plans for any reason. She explained that she did not rely on care plans, instead depended on the 24-hour report and other assessment tools. When asked about the implementation of person-centered care listed in the care plan, she stated she was not familiar with the concept of person-centered care plan and did not know how the care plans were implemented using the interventions listed. RN B stated she noted down the relevant interventions required during daily IDT meetings and perform the nursing care on day-to-day basis , based on the IDT meeting outcomes. During a phone interview on 03/20/26 at 3:50 p.m., LVN C stated she worked with Resident #1 and had not noticed the absence of care plans for his conditions. She stated that care plans were very important as they contain relevant information about residents' short- and long-term goals and the interventions needed to achieve them. LVN C stated she refer to care plans in the EHR when required, however, never received any in- services on careplan. During an interview on 03/20/26 at 4:00 p.m. the DON stated she was new to the facility and was unaware of the lack of a proper care plan for Resident #1. She said care plans were an essential part of nursing care, providing a person-centered perspective of residents' issues, goals, and interventions. She explained that nurses were expected to work according to the care plan to promote residents' maximum well-being. The DON added that care plans offer direction and serve as tools to achieve the goals of residents' stays, supported by the IDT team.During an interview on 03/20/26 at 4:20pm , the ADM stated that the MDSC worked remotely and was responsible for creating and updating care plans. He mentioned that Resident #1 was out of the facility for a while before re admitted on [DATE] and that, according to records, there were care plans in the past for Resident #1 . However, he indicated that the MDSC failed to transfer the care plan with the necessary updates after Resident #1's readmission. He described the process as straightforward and expressed uncertainty as to why Resident #1's conditions were not reflected in the current care plan, suggesting a possible system glitch. The ADM stated he would work with the MDSC to resolve this issue, emphasizing that an active, valid care plan is essential and an integral part of nursing care. The ADM stated it was the responsibility of the IDT and other staff members who were using the care plan to see if the care plan was complete and report to the ADM or DON if there was any shortfall. Record review of the facility's policy Care Planning revised on 10/24/2022 reflected : Purpose:To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.Policy:The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines.The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an ass needed bases. VIII. A culturally competent and trauma-informed comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.

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	03/20/2026

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 - Few	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** Based on interview and record review the facility failed to develop the comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 6 residents (Resident #1) reviewed for care plans.The facility failed to ensure that Resident #1's comprehensive care plan was completed within 7 days after completion of the comprehensive assessment, completed on 02/05/26.This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #1's face sheet dated 03/20/26 revealed a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Coronary Artery Disease (Limited blood flow in the arteries of the heart) , End-Stage Renal Disease (kidney failure), Heart Failure, Hypertension, Diabetes Mellitus , Peripheral Vascular Disease(blood circulation issues), Gastroesophageal Reflux Disease(acid reflux), Pneumonia, Chronic Obstructive Pulmonary Disease (breathing difficulty) , Hyperlipidemia (high cholesterol), Depression, Post Traumatic Stress Disorder (a mental disorder) , Anemia(tiredness) and Pain.Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating the cognition of the resident was intact. Further review of the MDS reflected that Resident #1 was actively diagnosed with medically complex conditions. They were Coronary Artery Disease, End-Stage Renal Disease, Heart Failure, Hypertension, Diabetes Mellitus , Peripheral Vascular Disease(blood circulation issues), Gastroesophageal Reflux Disease, Pneumonia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Depression, Post Traumatic Stress Disorder, Anemia and Pain.Record review of Resident #1's comprehensive care plan initiated on 03/05/26 revealed there was care plan only for Resident #1's noncompliance with facility smoking policies . The care plan included interventions to achieve the goal of compliance with facility smoking policy through the review date.There were no other care plans for Resident #1's medical, nursing, mental and other psychosocial needs.During an interview on 03/20/26 at 10:20am Resident #1 stated he was not happy with the nursing he received at the facility. He stated that he and his family member are in the process of looking for a better facility. Resident #1 said the staff at the facility were not doing their job properly . He mentioned that he received his medications sometimes not on time. He also said that recently he missed his watch and suspects that one of the staff members took it. Overall, he said his experience at the facility was not good.During a phone interview on 03/20/26 at 11:30am , the MDSC stated that he was responsible for initiating, updating, and completing care plans. He indicated that he was aware of the timing parameters for completing care plans. He said he was under the impression that he had completed the care plan within 7 days after the completion of Resident #1's MDS assessment on 02/05/26. The MDSC stated that care plans were an integral part of nursing care, providing relevant information about residents and their conditions, as well as appropriate interventions to address them. He stated a timely care plan was essential for the staff to understand what Resident #1's specific needs were, the goals, and the nursing interventions to be implemented to achieve these goals.During an interview on 03/20/26 at 4:00 p.m., the DON stated she was new to the facility and was unaware that there was no proper care plan for Resident #1 based on the quarterly MDS assessment that was completed on 02/05/26. She said timely completed care plans were an essential part of nursing care, providing a person-centered perspective of residents' issues, goals, and interventions. The DON added that care plans offer direction and serve as tools to achieve the goals of residents' stays, supported by the IDT team. The DON stated that Resident #1's missing care plan related to his medical conditions was a concern as careplan was an integral part of nursing care.During an interview on 03/20/26 at 4:20pm the ADM stated that the MDSC worked remotely and was responsible for creating and updating care plans. He mentioned that Resident #1 was out of the facility for a while before re-admitted on [DATE] and that, according to records, there were care (continued on next page)

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	03/20/2026

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 - Few	plans in the past for Resident #1. However, he indicated that the MDSC failed to transfer the care plan with the necessary updates after the completion of the recent quarterly MDS assessment. He described the process as straightforward and expressed uncertainty as to why Resident #1's conditions were not reflected in the current care plan, suggesting a possible system glitch. The ADM stated he would work with the MDSC to resolve this issue, emphasizing that a timely completed care plan was essential and was an integral part of nursing care. The ADM stated he would work with the MDSC to resolve this issue, emphasizing that a timely completed care plan was essential and was an integral part of nursing care.Record review of the facility's policy Care Planning revised on 10/24/2022 reflected : Purpose:To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.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.