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	05/07/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.The facility failed to ensure food items in the refrigerator were dated, labeled, and sealed appropriately.The failure could affect residents by placing them at risk for food-borne illnesses and food contamination.Findings included:Observations of the facility's kitchen refrigerator on 05/05/2026 at 9:23 a.m., revealed there was 1 sealed plastic container with cheese, it was not labeled or dated.Observation on 05/05/2026 at 9:36 a.m., revealed the ADS removing a cell phone from her pocket, she then placed it directly on the food preparation counter. Neither the cell phone nor the counter was sanitized before or after the cell phone was placed on the counter. Observation of the kitchen refrigerator on 05/07/2026 at 8:31 a.m., revealed there were 2 sealed plastic containers with cheese, they were not labeled or dated.Interview with the DS on 05/05/2026 at 9:18 a.m., revealed staff have been trained in food safety and prevention of cross contamination. The DS stated it is his responsibility to make sure food storage requirements are met. He stated, the facility guidelines require that food is to be labeled and dated to include the date it was received and the expiration date. He stated that it is his expectation that proper hand sanitation is done by all staff members while they are performing kitchen tasks. He stated if staff fails to follow hands sanitization procedures or food storage and labeling requirements it could cause cross contamination and residents are at risk for food borne illness. The DS stated, staff have been trained regarding use of cell phones in the kitchen. He said this could be a cause of cross contamination. During an interview on 05/05/2026 at 9:30 a.m., the ADS said she had been trained in food safety and she was in-serviced on hand sanitation. The ADS stated, I must wash my hands between tasks to prevent foodborne illness from spreading. During a phone interview on 05/06/2026 at 8:35 a.m., the RD revealed she had worked as a Dietary Consultant for 10 months. She stated, my scope of practice is the clinical side. She stated, I work with the care team, doctors and nurses, I provide education and diagnoses. She stated, I believe the facility does an excellent job of training staff on cross contamination. The RD stated staff cell phones should not be put on the food preparation surfaces as this could cause cross contamination. The RD was unaware that there was a cheese container that was undated in the refrigerator, she stated, undated food should not be used as it could be expired and it could cause someone to get sick. During an interview on 05/07/2026 at 8:35 a.m., the DA stated, when food is delivered to the facility, I label and date the food with the date it arrives and the day it expires. The DA was unaware that the cheese container in the refrigerator was not labeled and dated. She stated she was responsible for loading food on the trays per the resident's food plan. She stated that she had been trained to wash hands to the count of 20 seconds between tasks and she was to wear gloves when performing tasks in the kitchen. She stated residents could get sick if the staff does not use proper hand sanitation and / or if expired food is used.Record review of Dietary Safety Training Certificates revealed that 8 of 8 staff members had current food safety certifications. Review of facility Food Storage Guidelines last revised on 12/2020, revealed All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) .Record review of Hand Hygiene Policy revised 6/2020, revealed, The facility (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	considers hand hygiene the primary means to prevent the spread of infections.Procedure:Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.Hand hygiene observation may be observed and recorded by the Infection Control Designee monthly and results reported to QA.Facility Staff follow the hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors.Hand hygiene products and supplies (sinks, soap,.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy.Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too.Wash hands with soap and water:After contact with. Environmental surfaces.Was the cheese addressed specifically with the DSnoNoRemove name from document

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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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable state laws for 1 of 4 (ADON) staff reviewed for staff qualifications. The facility failed to ensure ADON had a valid nursing license to practice and was not expired on [DATE].This failure could place residents at risk for not receiving nursing services by a licensed nurse.The findings included:Record review of the staff roster for the facility indicated ADON had been employed at the facility since [DATE].Record review of the TBON license verification dated [DATE] indicated ADON was originally issued an LVN/LPN license on [DATE] and current expiration date was [DATE]. Record review of the license renewal application receipt issued by TBON indicated that the application for renewal was submitted by ADON with the required late fee, on [DATE]During an interview on [DATE] at 3:45pm the ADON stated she was notified by the facility on [DATE] that her license had expired. She stated she never thought she was practicing with an expired license and applied for renewal as soon as she came to know about it. She stated the license was not renewed yet by the TBON though the application and the fee for renewal was submitted at the end of [DATE]. She stated she rarely did bedside nursing tasks and mostly did administrative work. She stated her responsibility included providing in-services and training to the nursing staff and managing the nursing work force . She stated there were two to three occasions when she had to administer medications and assessments when nurses were not around, during the inactive licensure period. The ADON stated she did not believe her expired license impacted on her ability to do her job because of the expertise and experience she gained over the past 45 years.During an interview on [DATE] at 4:30pm the DON stated she was not aware that the licensure of ADON had expired and in the process of renewal. She stated , it was every nurse's responsibility to ensure that they have a valid active licensure. She added that it was a requirement as per the rule of the TBON to ensure the competency of the nurses. The DON stated as her assistant ADON was resourceful and did not notice any concerns or competence issues. During an interview on [DATE] at 4:50pm the ADM stated that the ADON had not notified him about her delinquent nursing license. He stated that he confirmed with the facility office that an application for renewal with late fee was processed on [DATE] and expecting the renewal anytime . He stated the ADON would not be doing any nursing tasks until her license has been activated . He stated he would create a system to track the expiry dates of the licenses of all the professionals who work at the facility so that their licenses could be renewed well in advance before they got lapsed. He stated ADON had wealth of experience as LVN and did not receive any alarm about any competency concern.The facility did not provide any policies related to licensure and credentialing staff.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or a centralized staff work area from each resident's bedside for 4 of 34 residents (Residents # 3, # 36, #46 and # 56) reviewed for call lights.The facility failed to ensure the call light system was accessible to Residents # 3, # 36, #46 and #56.These failures could place residents at risk of not being able to call for staff assistance to meet care needs or at risk of injury, pain, hospitalization, and a diminished quality of life.Record review of a face sheet dated 05/07/2026 indicated that R #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Spastic Diplegic Cerebral Palsy, (a neurological movement disorder characterized by high muscle tone (spasticity) causing severe stiffness and tightness, primarily affecting the legs more than the arms.) Aneurysm of Unspecified Site , (a localized, abnormal widening or ballooning of an artery wall that has not been definitively localized to a specific artery (such as the brain or aorta) in medical documentation.) Hypertension, (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body). Symptoms vary from person to person and generally include unexplained fatigue and headache.) Record review of a quarterly MDS assessment dated [DATE] for R #3 indicated a BIMS score was unable to be determined. Resident # 3 was rarely/never able to be understood and he had short term and long-term memory problems. Resident # 3 had limitations in range of motion, and he was impaired on both upper and lower extremities. Review of R #1 care plan dated 12-23-2025, had a behavior problem related to dementia. Her behavior is to hoard napkins, food and spoons. Interventions include anticipating and meeting the residents' needs. R# 1 participates in exercise. Interventions including the activity director will encourage and remind R # 1 of current activities. Record review of R # 3 's comprehensive care plan with a revision date 11/05/2025, revealed the R #3 had impaired cognitive function/dementia or impaired thought processes r/t neurological symptoms. R#3's goal is to maintain current level of cognitive function. Interventions are to Engage the resident in simple, structured activities that avoid overly demanding tasks. The resident has had an actual fall with No Injury, Unsteady gait. Therapy will work with R#3 regarding use of call light and safety awareness. During an observation and interview on 05/05/2026 12:46 p.m., R #3's call light was observed hanging off the right side of the bed, it was not within reach of R#3. R#3 stated that she did not know where the call light was. Resident #36 Record review of a face sheet dated 05/07/2026 indicated that R #36 was a [AGE] year-old female re-admitted to the facility on [DATE] with diagnoses including: PULMONARY HYPERTENSION, (high blood pressure), SCHIZOPHRENIA, (a chronic, severe brain disorder that affects how a person thinks, feels, and acts, often causing them to lose touch with reality) and BIPOLAR DISORDER(includes bouts of hypomania or mania and sometimes major depression.) Record review of a Quarterly MDS assessment dated [DATE] for R #36 indicated that her BIMS score could not be determined. The MDS assessment for Resident # 36's mobility indicated she required Supervision or touching assistance- Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Record review of the Care Plan dated 04/14/2026, indicated that R# 36 had an ADL Self Care Performance Deficit r/t Impaired balance. R#36's interventions are to Encourage the resident to use bell to call for assistance. During an observation and attempted interview of R# 36 on 05/06/2026 at 10:50 a.m., R# 36 was lying in her bed, she was sleeping and the call light was located out of R#36's reach on the floor, near the foot of her bed. Resident #46 Record review of R # 46's face sheet dated 05/07/2026 indicated that R #46 was a [AGE] year-old male re-admitted to the facility on [DATE] with diagnoses including: ACUTE RESPIRATORY FAILURE WITH HYPOXIA (a sudden, life-threatening condition where the lungs cannot adequately oxygenate the blood, resulting in a low partial pressure of oxygen.) TYPE 2 DIABETES, a chronic condition characterized by insulin resistance and high blood (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sugar levels.) And REFLUX DISEASE, (the backward flow of liquid, specifically when stomach acid or contents travel up into the esophagus (throat). Record review of a Quarterly MDS assessment dated [DATE] for R #46 indicated a BIMS score of 6 indicating he had a severe problem with thinking and memory. The assessment of R #46's mobility indicated he was dependent, and he needed 2-person assistance using a Mechanical lift. Record review of the Care Plan dated 04/10/2026, for R # 46 indicated the resident's call light was to be within reach and encourage the residents to use it for assistance as needed. In an observation and interview on 05/05/2026 at 12:40 p.m., R#46's call light button was resting on the bedside table, and it was out R #46's reach. The RP stated R#46 needed assistance with ADLs. The RP said R#46 does not know how to get in touch with the staff. Resident #56 Record review of R# 56 's face sheet dated 05/07/2026 indicated that R #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Dementia (confusion due to aging with inability to remember), HEART FAILURE, (a chronic, serious condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen.) and RHEUMATOID ARTHRITIS,(a chronic, autoimmune disease where the immune system mistakenly attacks the lining of joints (the synovium), causing painful inflammation, swelling, stiffness, and potential joint deformity.) Record review of a Quarterly MDS assessment dated [DATE] for R #56 indicated a BIMS score of 9 indicating he had moderate cognitive impairment. The assessment of R #56's mobility indicated he needed supervision or touching assistance- helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity. Record review of the Care Plan dated 03/17/2026, for R # 56 indicated the staff was to be sure R#56's call light was within reach and encourage the him to use it. During an observation and interview on 05/06/2026 at 10:49 a.m., R# 56 was sitting on his bed, and no call light was seen in R#56's room. R# 56 stated he does not know how he would contact staff for help, he said he was not sure how often the staff came into his room and checked on him. During an interview on 05/07/2026 at 12:05 p.m., CNA F stated she had been in-serviced regarding call light location, and CNAs are responsible for making sure the location of call lights are within reach of each resident. She stated, Residents call lights are important for them to be able to reach out for help. If a resident has a fall, they will need immediate assistance. And she stated, Call lights should be pinned to the resident's bed, it should be close to the residents hand. During an interview on 05/07/2026 at 12:34 p.m., RN E stated, everyone on staff is responsible for checking the call light button locations. She said, the type of call light used for a resident is determined when the resident is assessed for functional abilities. The IDT including the Therapy team will have input as to the type of call light that is best for that person. RN E said, per the policy, a residents call light must be within reach of the resident. She said if a call light is not within residents' reach, the residents may not be able to get the help they need. During an interview on 05/07/2026 at 4:05 p.m., the DON revealed that call lights should be clipped on to the bed and it should be within each residents' reach. The DON stated, residents who have problems with dexterity may need a specialized call light. The DON stated, it is not acceptable for call light to be on the floor. The DON stated that CNAs are responsible for checking on the call light locations. During an interview on 05/07/26 at 04:49 p.m., the ADM said that he expects that staff will follow the policies and procedures regarding call lights. He stated that staff have been in-serviced on placement of call lights. The ADM stated, each resident should have a call light within reach of residents. Record review facility policy titled Communication- Call System date revised 10-24-2022 indicated: The Facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities.The call system should be accessible to a resident lying on the floor in toileting and bathing facilities.ProcedureII. Call cords will be placed within the resident's reach in the resident's roomIII. Nursing staff will answer call bells promptly, in a courteous manner.IV. Upon responding to request, if item is requested is questionable, assistance will be obtained from the Charge Nurse.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment for 1 of 8 (Resident #13) residents reviewed for homelike environment. The facility failed to ensure that shower curtains did not contain brown, unidentifiable substances and that the shelf in the shower room did not contain a yellow unidentifiable substance. These findings could place residents at risk for living in an environment that is not homelike. Findings included:A record review of Resident #13's face sheet dated 5/07/2026 reflected a [AGE] year-old male readmitted on [DATE] with diagnoses of bipolar disorder (manic depression), peripheral vascular disease (reduced blood flow), schizophrenia (mental health condition), generalized anxiety, heart failure, hypertension (high blood pressure), and mild cognitive impairment. A record review of Resident #13's MDS assessment dated [DATE] reflected a BIMS score of 14, which indicated minimally impaired cognition. Resident #13's MDS assessment reflected that he was independent with personal hygiene ADLs. A record review of Resident #13's care plan revised on 9/08/2023 reflected that he had potential to demonstrate verbally abusive behaviors related to infective coping skills. Interventions included that staff were to assess resident's understanding of the situation and allow time for the resident to express self and feelings towards the situation. During an observation and interview on 5/05/2026 at 2:45 PM, Resident #13 was observed in the hallway. Resident #13 stated that the shower rooms had shit on the floor. Observations of the shower room between 2300 and 2200 halls revealed there was an unidentifiable brown substance on the floor and on the curtain. There was also an unidentifiable yellow substance on the shower room shelf. During an observation on 5/06/2026 at 9:29 AM revealed that there was still a yellow unidentifiable substance on the shower room shelf and a brown unidentifiable substance on the shower curtain. During an observation and interview on 5/07/2026 at 2:44 PM, RN E stated that the shower rooms were cleaned every day on every shift and that the brown substance on the curtain could be poop. During an interview on 5/07/2026 at 2:50 PM, RN C stated that the yellow unidentifiable substance on the shower shelf could be something that spilled. RN C stated the brown stain on the shower curtain was either food or poop. During an interview on 5/07/2026 at 3:25 PM translated by HHSC's translating services, HK D stated that the process of cleaning the showers involved taking garbage out, disinfecting, sweeping and washing up with the mop. HK D stated that shower curtains were cleaned every time she cleaned the shower room. HK D stated that maybe she needed to try cleaning the curtain with something stronger. During an interview on 5/07/2026 at 4:27 PM, the DON stated, we're supposed to make it as similar as it can be to living at home. The DON stated she had not walked into the shower rooms in the past couple of days, but after each resident finished receiving a shower, staff were supposed to disinfect the shower rooms. The DON stated if the shower curtains had stained, staff needed to let maintenance know so housekeeping could launder them. The DON stated she was not sure when the last time the curtains were cleaned. When asked how the stained cabinet and curtains could affect residents'' environment, the DON stated, I don't think it's very inviting and bacteria could grow. During an interview on 5/07/2026 at 4:37 PM, the ADM stated that if there were any issues related to homelike environment, staff should report it to the respective department. The ADM stated that his expectation was, if they see it, they should say something. When asked how yellow and brown stains in the shower room could affect residents, the ADM stated, you don't want to see it. A record review of the facility's policy titled Resident Rights dated August 2020 reflected the following: PurposeTo promote and protect the rights of all residents at the Facility.PolicyAll residents have a right to a dignified existence, self-determination, and communication with andaccess to persons and services inside and outside the facility including those specified in thispolicy. The Facility must treat each resident with respect and dignity and care for (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each residentin a manner and in an environment, that promotes maintenance or enhancement of his or her qualityof life, recognizing each resident's individuality.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 5 of 8 residents (Resident #12, Resident #45 , Resident #86 , Resident #95 and Resident#57,) reviewed for respiratory care. The facility failed to ensure that :The oxygen cannula, nebulizer masks and tubing of Resident #36 and Resident #95 were stored safely in protective bags. ?oxygen in use sign board displayed in the rooms of Resident #12, Resident #57, and Resident #86These failures placed residents at risk for fire safety and respiratory infections through contamination.Findings included:Resident #36Record review of Resident #36's face sheet, dated 05/06/26, reflected Resident #36 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #36 was a [AGE] year-old female, diagnosed with acute respiratory failure with hypoxia (low oxygen intake) and COPD(breathing difficulty). Record review of Resident #36's quarterly MDS dated [DATE] revealed BIMS assessment could not be completed as the resident rarely/never understood the assessment questions. The MDS indicated of oxygen therapyRecord review of Resident #36's care plan had not addressed her diagnosis of COPD and respiratory failure with hypoxia .Record review of Resident #36's physician's order reflected Oxygen @ 2-4 l/m via nasal canula to reach saturation 90% or higher/hypoxia every shift for as needed for SOB/hypoxia related to acute respiratory failure with hypoxia . Monitor O2 saturation.-Order Date- 11/29/2025.Record review of the April and May 2026 MAR of Resident #36 revealed Resident#36 received Oxygen via nasal cannula 2 times every day.During observation and interview on 05/05/26 at 10:35am Resident #36 was in her room and resting in wheelchair. Her oxygen cannula from the concentrator was on the ground and the water bottle on the oxygen concentrator had a sticker 4/19/26 written on it. There was no protective bag available in the room for keeping the cannula when it was not in use. Resident #36 stated she received the oxygen two times every day . She said the staff were helpful and provided the oxygen and medications without fail.Resident #95Record review of Resident #95's face sheet, dated 05/05/26, reflected Resident #95 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #95 was a [AGE] year-old female, diagnosed with acute respiratory failure with hypoxia, COPD and moderate persistent asthma Record review of Resident #95's quarterly MDS dated [DATE] revealed BIMS 14 indicating her cognition was intact. The MDS indicated oxygen therapy.Record review of Resident #95's care plan dated 09/04/25 reflected the resident had asthma r/tCOPD. The relevant intervention was providing medications as ordered and monitoring /documenting side effects and effectiveness.Record review of Resident #95's physician's order reflected:* Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG (Umeclidinium Bromide) : 1 inhalation inhale orally as needed for COPD -Order Date- 06/23/2023. * Respiratory evaluation before Nebulizer treatment every 2 hours as needed for SOB.-Order Date- 07/05/2023.* Respiratory evaluation after Nebulizer treatment every 2 hours as needed for SOB.-Order Date- 07/05/2023.During an observation and interview on 05/05/26 at 10:50am it was revealed that the nebulizing mask of Resident #95 was not in a protective bag and was lying on the side table exposed to the open air. Resident #95 stated she uses nebulizer for shortness of breath on PRN basis and could not remember when she had it last. She stated her respiratory issue improved recently however staff provided the medication via nebulizer when in need as per her request.Resident #86Record review of Resident #86's face sheet, dated 05/05/26, reflected Resident #86 was admitted to the facility on [DATE]. Resident #86 was a [AGE] year-old female, diagnosed with chronic respiratory failure with hypoxia. Record review of Resident #86's quarterly MDS dated [DATE] revealed her BIMS assessment could not be completed as she rarely/never understood the assessment questions. MDS indicated oxygen therapy.Record review of Resident #86's care plan (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 04/05/26 reflected the resident had oxygen therapy r/t CHF and ineffective gas exchange.Record review of Resident #86's physician's order reflected Oxygen @ 2-4 liters via nasal cannula every shift related to chronic respiratory failure with hypoxia.Order Date- 04/10/2026During an interview and observation on 05/05/26 at 11:00am it was revealed that Resident #86 was connected to the oxygen concentrator via nasal cannula for continuous oxygen supply however there was no Oxygen in use sign board on her room. Resident #86 stated her respiratory condition was very bad and needed continuous supply of oxygen. Resident #12Record review of Resident #12's face sheet, dated 05/05/26, reflected Resident #12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #12 was a [AGE] year-old male, diagnosed with chronic respiratory failure. Record review of Resident #12's quarterly MDS dated [DATE] revealed BIMS 14 indicating his cognition was intact. MDS indicated oxygen therapyRecord review of Resident #12's care plan dated 03/20/26 reflected he had emphysema/COPD and the relevant intervention was administering aerosol or bronchodilators as ordered and monitoring for any side effects.Record review of Resident #12's physician's order reflected Oxygen 1-5 LMP via NC as needed for SOB.-Order Date- 09/23/2025During an observation and interview on 05/05/26 at 11:30am Resident #12 was resting in his bed. There was an oxygen concentrator in his room without an ?oxygen in use' signboard. Resident #12 stated he was improving with his breathing capacity, needed oxygen occasionally and the staff provided when requested.Resident #57Record review of Resident #57's face sheet, dated 05/05/26, reflected Resident #57 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #57 was a [AGE] year-old female, diagnosed with acute and chronic respiratory failure, COPD, emphysema (a progressive, chronic lung disease) and shortness of breath.Record review of Resident #57's quarterly MDS dated [DATE] revealed BIMS 13 indicating her cognition was intact. MDS indicated oxygen therapy. Record review of Resident #57's care plan reflected she was on Oxygen Therapy r/t ineffective gas exchange and COPD. The relevant intervention was administering oxygen as per physician's order.Record review of Resident #57's physician's order revealed O2 @ 2.5 liters per minute via nasal cannula every shift-order date 12/23/2025.During an observation and interview on 05/05/26 at 11:45am Resident #57, she was in her bed . She had continuous supply of oxygen via a cannula that was connected to an oxygen concentrator. There was no oxygen in use sign board in her room. She stated she has severe breathing issue and needed continuous supply of oxygen. Resident said the staff was supportive in providing care.During an observation and interview conducted with LVN J on 05/05/26, at 11:15 a.m., LVN J observed that the oxygen cannula belonging to Resident #36 was lying on the floor. She promptly picked it up for disposal, noting that it should have been stored in a protective bag. LVN J stated that she would immediately change the water bottle of the oxygen concentrator, which had been sitting in place since 04/19/26. She stated that, according to facility protocol, the cannula and water bottle were to be replaced weekly to minimize the risk of respiratory infection. LVN J indicated that the purpose of these interventions was to reduce the potential for respiratory infections among residents. She said she would make arrangements to display Oxygen in Use signage for Resident #12 and Resident #86 to enhance safety precautions.During an observation and interview conducted on 05/05/26 at 11:35 a.m., RN E noted that the nebulizing mask belonging to Resident #95 was found lying on the side table. RN E stated that the mask should have been stored in a protective bag when not in use. She removed the unprotected mask and tubing. RN E explained that failure to protect respiratory equipment from external environmental factors poses a risk of cross-contamination and microorganism colonization, which could potentially lead to serious respiratory infections and other health complications. She said that it was the responsibility of nursing staff to ensure proper storage of respiratory equipment in protective bags. RN E stated that she should have identified this noncompliance earlier and taken corrective action. RN E stated that she would immediately display an Oxygen in Use signage for Resident #57 to warn staff and visitors of the fire hazard associated with oxygen therapy. In an interview conducted on 05/07/26 at 4:30 p.m., the DON stated that nebulizer masks, tubing, and oxygen nasal cannulas should be cleaned and (continued on next page)

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	455799	A. Building B. Wing	05/07/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored in a clean protective bag after use. She explained that this practice was intended to minimize the risk of respiratory infections caused by contaminated equipment. The DON further clarified that it was the nurses' responsibility to ensure that this process was completed following medication administration. She highlighted that residents sometimes remove their respiratory equipment and forget to replace it in the protective bags, emphasizing the importance of regular rounds by nursing staff to verify proper storage of respiratory devices. Additionally, the DON addressed the challenge related to maintaining Oxygen in Use signage, noting that one resident at the facility had taken down the signage displayed on the board. She said that staff recently discovered a bundle of various signage types stored among that resident's belongings. The DON stated that staff should have been more vigilant regarding the disappearance of the signage and emphasized the need for daily rounds to ensure that signage boards remain undisturbed and properly displayed.Record review of the in-service since [DATE] revealed there were no in services on safe handling of respiratory equipment.Review of the facility policy Oxygen Administration revised on 06/2020 reflected: . III. Infection ControlA. All oxygen tubbing, humidifiers, masks, and cannulas used to deliver oxygen:i. Are for single resident use only.ii. Will be changed weekly and when visibly soiled, or as indicated by stateregulation.B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect theequipment from dust and dirt when not in use.IV. Safe Handling of Oxygen/EquipmentA. Residents using oxygen will have an Oxygen in Use sign placed on the door frame oftheir room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were labeled and stored in accordance with currently accepted professional principles for 2 of 4 medication (Med) carts (Med cart 2100 and Med cart 2400) reviewed for storage.The facility failed to ensure MA B did not store his personal belongings in the Med cart 2100 and Med cart 2400on 05/06/26.These deficient practices could place residents at risk of receiving cross-contaminated medications.Findings included:During an observation and Interview on 05/06/26 at 11:35 AM MA B facilitated the surveyor in reviewing medication labelling and storage in the medication carts. During the inspection, it was revealed that a one-dollar currency notes and a pair of sunglasses belonging to MA B were stored in one of the drawers of Med Cart 2400. Observation of Med Cart 2100, a black backpack belonging to MA B was found stored in the bottom drawer. The backpack contained assorted personal belongings, including a personal medication organizer box. MA B stated it was a blunder on his part and stated that, as a responsible medication aide, he should not have stored his personal belongings in a medication cart designated exclusively for residents' medications. He said that storing personal items in the cart increased the risk of cross-contamination of the medications stored there.During an interview on 05/07/26 at 4:30 p.m. , the DON stated that staff should not place any personal items in the medication carts, as this could pose a risk of cross-contamination. She said that the medication storage room and medication carts were intended solely for storing residents' medications, and nothing else should be kept there. She highlighted that this practice was important for the proper management of medications to minimize errors and prevent infections caused by contamination.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration for 3 of 8 residents (Residents #30, #56 and #90) reviewed for hydration, in that: The facility failed to ensure R #30, R# 56, R #90 had access to water and/or beverages in their rooms between meals. These deficient practices could affect resident's hydration and lead to discomfort, dehydration, and/or a diminished quality of life. Record review of R# 30's face sheet dated 05/07/2026 revealed a [AGE] year-old male with an admission date of 09/02/2025 with diagnoses which included: Hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body). Symptoms vary from person to person and generally include unexplained fatigue and headache.) VASCULAR DEMENTIA, (A condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain. It causes problems with reasoning, planning, judgment, and memory), and TYPE 2 DIABETES (A condition results from insufficient production of insulin, causing high blood sugar.) Record review of R #30's quarterly MDS dated [DATE] revealed a BIMs score of 4 which indicated severe cognitive impairment. The MDS indicated R #30 required supervision or touching assistance - helper provides verbal cues and/or touching / steadying and/or contact guard assistance as resident completes activity and ADLs such as Oral hygiene. And R#30 was independent with ADLS such as eating and toileting. Record review of R #30's care plan last revised on 03/06/2026 revealed he was able to hold a cup and feed himself. The care plan revealed R#30 had nutritional problems or potential nutritional problems. R#30's goal is the resident will maintain adequate nutritional status through review date. During an observation and interview on 05/6/2026 at 10:51 a.m., revealed R # 30 did not have a water cup available or within reach. Resident #30 said that he did not know where the cup was and that he would like to have a water cup. Resident #56 Record review of R # 56 's face sheet dated 05/07/2026 indicated a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Dementia (confusion due to aging with inability to remember), HEART FAILURE, (a chronic, serious condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen.) and RHEUMATOID ARTHRITIS,(a chronic, autoimmune disease where the immune system mistakenly attacks the lining of joints (the synovium), causing painful inflammation, swelling, stiffness, and potential joint deformity.) Record review of a quarterly MDS assessment dated [DATE] for R #56 indicated a BIMS score of 9 indicating he had moderate cognitive impairment. The assessment of R #56's mobility indicated he needed supervision or touching assistance- helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity. Record review of the Care Plan dated 03/17/2026, for R # 56 indicated the staff was to be sure the resident's call light was within reach and encourage the resident to use it. During an observation and interview of R #56 on 05/06/2026 at 10:49 a.m., it was revealed that R# 56 was sitting on his bed, and no water cup or water pitcher was seen in R#56's room. R# 56 stated he does not know why he does not have water, he said he did not know that he was supposed to have water between meals. Resident #90 Record review of R #90's face sheet dated 05/07/2026 revealed a [AGE] year-old male with an admission date of 03/21/2025 with diagnoses which included: EPILEPSY, (A neurological disorder that causes seizures or unusual sensations and behaviors.), DYSPHAGIA, (difficulty swallowing) and PARKINSON'SDISEASE, (A progressive disorder that affects the nervous system and the parts of thebody controlled by the nerves.) Record review of R #90's quarterly MDS dated [DATE] revealed a BIMs score of 11 which indicates moderate problems with thinking and memory. The MDS indicated R #90 required assistance for set up or clean- up regarding ADLS such as eating and bringing food and/or liquid to the mouth. During an observation and interview on 05/06/2026 at 10:50 a.m., R #90's room did not have any water, beverages, or water (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pitcher at bedside. R #90 said, he was not sure why he didn't have water by his bedside. R# 90 said, I like water. During an interview on 05/07/2026 at 12:05 p.m., CNA F revealed all residents should be provided with adequate hydration. She stated that CNAs are responsible for providing water to each resident. She stated the water should be within arm's length of the resident and if they don't have enough water they could suffer from dehydration. CNA F Said she did not know why R# 90 did not have a water cup by his bedside. She said he is a new patient, and I don't know him very well. During an interview on 05/07/2026 at 12:34 p.m., RN E revealed that staff are responsible for performing rounds every 2 hours. She said, every resident will have their cup filled up with ice and water every time it is needed. She said, water is an essential, they need water for life. During an interview and interview on 05/07/2026 4:05 p.m., the DON stated, staff are supposed to follow protocol regarding hydration. She stated that every resident should have their cup filled up frequently. She said no one should have an empty cup of water. She said if they do not get enough water, they may become dehydrated. During an interview on 05/07/2026 at 4:49 p.m., the ADM revealed that every staff member is expected to follow policies and procedures regarding hydration for residents. He stated all staff have been in-serviced on policies for hydration and call lights. He stated they should know they are supposed to place water within each residents reach and they should assess the residents' need for water when they do rounds to each room. The ADM does not know why # R #30, R# 56, R #90 do not have water available in their rooms. Record review of the facility's policy titled Hydration revised 10/05/16 indicated . The facility provides each resident with sufficient fluid intake to maintain proper hydration and health. The residents will receive enough fluid based on assessed need to prevent dehydration and promote optimum physiological functions Staff should offer hydration, unless contraindicated at the following intervals: prior to, during, and following meals .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 3of 4 residents (Resident #45 Resident # 28 and Resident #56) reviewed for incontinence care and infection control.The facility failed to ensure that :CNA G and CNA H handling personal care items with clean gloves while providing incontinent care for Resident #45. MA I sanitized the blood pressure monitor before and in-between use on Resident #56and Resident #28, while obtaining blood pressure.This failure could place the residents at the facility at risk of transmission of disease and infection.Findings included:Resident #45Record review of Resident #45's face sheet, dated 05/07/26, reflected Resident #45 was admitted to the facility on [DATE]. Resident #45 was an [AGE] year-old female, diagnosed with cerebrovascular disease, cognitive communication deficit, muscle weakness, and dementia. Record review of Resident #45's quarterly MDS dated [DATE] revealed BIMS 10 indicating her cognition was moderately impaired. The Resident was dependent on ADL support Record review of Resident #45's care plan revealed she had ADL self-care performance deficit . provide care and the intervention was providing required ADL care. During an observation on 05/07/26 at 1:40 p.m., CNA G and CNA H provided incontinent care to Resident #45. CNA G and CNA H entered Resident #45's room, they did not perform hand hygiene, and both donned disposable gloves. After removing the soiled brief, CNA G proceeded to clean the resident's front and back while CNA H maintained appropriate positioning of the resident. CNA G applied a new brief without changing the contaminated gloves. CNA G operated the bed's remote control to adjust the height using unclean gloves, and CNA H tidied the bed and pulled up the blanket with the soiled gloves. CNAs removed their gloves, collected waste materials, and left the room. In an interview at 1:55 p.m., CNA H stated that she contaminated her gloves by touching the resident's body and handling dirty materials. She stated that she should have changed her gloves before handling clean items to prevent contamination. CNA H further indicated that she had been trained in performing incontinence care and was aware of the risk of germ transmission when infection control practices are not properly followed. In a phone interview at 2:20 p.m., CNA G stated she contaminated clean items with soiled gloves. She stated that she should have changed her gloves after completing the cleaning process and before handling the new brief. CNA G reported that the facility provided infection control and peri-care training during her job orientation four months prior. She said that her actions could pose a risk of disease transmission through contamination, which could potentially impact on residents' health. Resident #28 Record review of Resident #28's face sheet, dated 05/06/26, reflected Resident #28 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #28 was a [AGE] year-old male, diagnosed with hypertension.Record review of Resident #28's quarterly MDS dated [DATE] revealed BIMS 0 indicating his cognition was severely impaired.Record review of Resident #28's care plan had not addressed his diagnosis of hypertension.Record review of Resident #28's physician's order reflected Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate): Give 1 tablet by mouth one time a day related to essential (primary) hypertension. Hold for BP less than 110/55 or Pulse less than 60. - Order Date-03/30/2026Resident #56 Record review of Resident #56's face sheet, dated 05/06/26, reflected Resident #56 was admitted to the facility on [DATE]. Resident #56 was a [AGE] year-old male, diagnosed with hypertension.Record review of Resident #56's initial MDS dated [DATE] revealed BIMS 09 indicating his cognition was moderately impaired.Record review of Resident #56's care plan had not addressed the diagnosis of hypertension.Record review of Resident #56's physician's order reflected:* Lisinopril Tablet 10 MG :Give 1 tablet by mouth one time a day for hypertension hold forsystolic less than 110 -Order Date- 04/17/2026* Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG: Give 1 tablet by mouth two times a day for blood pressure control hold for systolic less than 110 or HR less than 60.-Order Date-04/17/2026 0637During an observation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 05/06/26 at 10:50 a.m., MA -I measured Resident #56's blood pressure with the wrist monitor without prior sanitization. After administering medications to Resident #56, she proceeded to use the same monitor on Resident #28 without sanitizing it first. She only sanitized the monitor after Resident #28 when the investigator pointed out the omission.During an interview on 05/06/26 at 11:25 a.m. MA I stated that she had been employed at the facility for approximately two months and had 16 years of experience as a medication aide. She reported that she had not received any training on the importance of sanitizing medical equipment between patients at the facility. She stated was aware of the significance of sanitizing medical equipment, from her experience as med aide, forgetting to do so due to being in a hurry. MA I stated that sanitizing blood pressure cuffs between residents helps reduce the risk of transmitting infectious diseases through contamination.During an interview on 05/07/26 at 4:30 p.m. the DON stated that her expectation was for all staff to sanitize medical equipment, including blood pressure cuffs, between residents. She reported observing deficiencies in infection control practices during routine rounds. The DON said that, based on MA I's comment about not receiving specific training on sanitizing medical equipment after starting employment, sanitization procedures are considered part of standard precautions for infection control and were included in initial orientation. The DON indicated that additional topics related to sanitizing medical equipment had not been routinely included in in-service sessions. She further stated that CNA G and CNA H also did not follow infection control protocols during incontinent care, which increased the risk of contamination of clean items. The DON concluded that the improper practices of MA I, CNA G, and CNA H heightened the potential for the spread of infectious diseases.Record review of facility policy Infection prevention and control program revised in 06/2020 reflected :Purpose: To ensure the facility establishes and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements .Record review of facility policy Cleaning & Disinfection of Environmental Surfaces revised in October 2024 reflected :Policy : Environmental surfaces are cleaned and disinfected per current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard .Procedure:C. Non-critical items are those that come in contact with intact skin but not mucous membranes.The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in the resident's environment.Non-critical items are those that come in contact with intact skin but not mucous membranes. i. Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors.ii. Most non-critical items can be decontaminated where they are used, as opposed to being transported to a central processing location.iii. Some items that can come in contact with non-intact skin for a brief period of time are usually considered non-critical surfaces as well and are disinfected with intermediate-level disinfectants.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents had the right to manage their financial affairs and to know in advance what charges a facility may impose against a resident's personal funds for 1 of 8 (Resident #70) residents reviewed for personal funds. The facility failed to distribute Resident #70's personal needs allowance in full. This failure placed residents at risk of not having access to their funds and a decreased quality of life.Findings included: A record review of Resident #70's face sheet dated 5/07/2026 reflected an [AGE] year-old female readmitted on [DATE] with diagnoses of dementia (neurocognitive disorder), muscle weakness, chronic obstructive pulmonary disorder (progressive lung disease), major depressive disorder, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and chronic kidney disease. A record review of Resident #70's MDS assessment dated [DATE] reflected a BIMS score of 6, which indicated moderately impaired cognition. A record review of Resident #70's care plan revised on 3/30/2026 reflected that she experienced increased agitation and anxiety related to environmental stimuli. Interventions included that staff would provide gentle redirection and reassurance to resident as needed to promote calm behavior. During an observation and interview on 5/06/2026 at 10:04 AM, Resident #70 stated that she had problems with her money. Resident #70 stated that she was only getting $60 per month and she was supposed to received $75. Resident #70 stated that it had been going on for the past couple of months. Resident #70 stated that she had talked with the Receptionist about this issue, and the Receptionist told her no she could not get her money. A record review of the facility's document titled Customer Balance Detail dated April 30, 2026 reflected that Resident #70 received petty cash payments of $60.00 on 1/05/2026, 2/05/2026, 3/06/2026, and 4/03/2026. During an interview on 5/07/2026 at 8:50 AM, the BOM stated that Resident #70 should be getting $75 and that the Receptionist handed out funds for residents' personal needs allowance. The BOM stated that the CFO gave the money to the Receptionist and the Receptionist gave it to residents. The BOM stated that she was not involved with the process. During an interview on 5/07/2026 at 8:55 AM, the BOM stated that she would fix Resident #70's account, that's an easy fix and that she believed it was an error that she was only receiving $60 per month because the guideline was that everyone got $75. The BOM stated yes that if there were complaints about the personal needs allowance, she would expect those concerns to be communicated to her. When asked how not receiving the correct amount of money each month could affect Resident #70, the BOM stated she did not think it would affect her because she was not sure whether Resident #70 picked up her money every month. The BOM stated that residents had to request their PNA each month. During an interview and record review on 5/07/2026 at 8:56 AM, the Receptionist stated that Resident #70 complained that she was not receiving as much money each month as she should. The Receptionist stated that she had not brought up this concern with the BOM, but I should have. The Receptionist pulled a sheet of paper that had a table with resident names listed next to an amount, the document reflected that Resident #70's name was listed and next to her name , it said 60 under a column titled amount. During an interview on 5/07/2026 at 12:14 PM, the BOM stated that petty cash listed on Resident #70's ledger was her PNA. During an interview on 5/07/2026 at 4:27 PM, the DON stated that her understanding of the policy on PNA was that residents talked with the Receptionist, told her how much they wanted, signed it out, and then had a witness sign. The DON stated yes she would expect a resident complaint to be escalated to the BOM or to the ADM. The DON stated I guess it would be against her rights if residents did not receive their full PNA. During an interview on 5/07/2026 at 4:37 PM, the ADM stated he believed residents were allowed $75 per month for their PNA. The ADM stated no it had not been brought to his attention that Resident #70 was not receiving her PNA in full. The ADM stated it was a resident right and that's her right to get it. A record review of the facility's policy titled Resident Funds - Handling & Reporting dated August 2020 reflected the following: PurposeThe objectives of (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this policy are to: Provide a means to protect resident funds managed by the Facility;.ProcedureManagement of Resident Funds.No licensee, owner, Administrator may act as an authorized representative of resident funds, unless the resident is a relative within the second degree of relation.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 3 residents (Resident #1) reviewed for privacy.The facility failed to ensure CNA G and CNA H provided privacy by closing the door and drawing the privacy curtain during incontinent care for Resident #45.This failure could place residents at risk of lack of privacy and not having residents' rights acknowledged.The findings include:Record review of Resident #45's face sheet, dated 05/07/26, reflected Resident #45 was admitted to the facility on [DATE]. Resident #45 was an [AGE] year-old female, diagnosed with cerebrovascular disease (stroke), cognitive communication deficit, muscle weakness, and dementia.Record review of Resident #45's quarterly MDS dated [DATE] revealed BIMS 10 indicating her cognition was moderately impaired.Record review of Resident #45's care plan revealed the resident had an ADL self-care performance deficit and the intervention was providing required ADL care. During an observation on 05/07/26 at 1:30 p.m., CNA G and CNA H provided incontinent care to Resident #45 in her room. CNA G and CNA H closed the door but they did not fully draw the privacy curtain during the procedure. Resident #45 shared the room with another resident, with her bed positioned near the door. Her roommate was not present at that time, the incontinent care was potentially fully visible to anyone entering the room or to her roommate if she or others entered during the care.In an interview at 1:45 p.m., Resident #45 stated that she believed CNA G and CNA H performed the care satisfactorily and was pleased with the service. She also noted that she did not observe whether the privacy curtain was fully closed or if the door to her room was shut. Resident #45 expressed that she would not feel comfortable if an unidentified visitor or her roommate observed her during personal care activities.During an interview on 05/07/26 at 1:55 p.m., CNA H stated that she should have drawn the privacy curtain but admitted she was nervous and forgot to do so. She emphasized that providing privacy during nursing care was essential because privacy and dignity are fundamental resident rights.During a telephone interview on 05/07/26 at 2:20 p.m. CNA G stated that incontinent care was a routine part of her responsibilities. She said that it was a mistake that the privacy curtain was not fully closed. CNA G explained that she believed it was unacceptable to keep the curtain partially or fully open, as the peri-care could have been visible to Resident #45's roommate or anyone entering the room at that time. She recognized that her oversight compromised Resident #45's right to privacy and dignity during the procedure.During an interview on 05/07/26 at 2:30 p.m., RN E stated that closing the door and drawing the privacy curtain were crucial to ensuring the privacy and dignity of residents. She indicated that CNA G and CNA H should have been diligent in maintaining compliance with this aspect of resident rights.During an interview on 05/07/26 at 4:30 p.m., the DON stated that respecting and upholding residents' privacy and dignity during nursing care, including incontinent care, involves closing doors, windows, and privacy curtains. The DON acknowledged that the door and privacy curtain of Resident #45 should have been fully closed prior to initiating care. She said that Resident #45's privacy could be violated if anyone entered the room during care. The DON further stated that resident rights are part of ongoing staff training, with all nursing staff required to complete an annual evaluation to ensure competence in respecting residents' rights and maintaining proper nursing practices.Record review of facility policy Resident Rights-Quality of life revised in 08/2020 reflected: Purpose: To ensure that all residents are treated with the level of dignity they are entitled to while residing at the facility.Policy: Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality. X. Facility Staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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	05/07/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 2 of 8 (Resident #9 and Resident #34) residents reviewed for activities of daily living. The facility failed to ensure Resident #9 and Resident #34's nails were trimmed and clean. This failure placed residents at risk for poor hygiene and decreased quality of life.Findings included: A record review of Resident #9's face sheet dated 5/07/2026 reflected a [AGE] year-old male readmitted on [DATE] with diagnoses of Alzheimer's disease (neurocognitive disorder), cerebral infarction (stroke), dysphagia (difficulty swallowing), weakness, unspecified lack of coordination, other reduced mobility, other lack of coordination, muscle weakness, and need for assistance with personal care. A record review of Resident #9's MDS assessment dated [DATE] reflected that he was not assessed for a BIMS score. Resident #9's MDS assessment reflected that he had not been assessed for his ability to maintain personal hygiene. A record review of Resident #9's care plan revised on 1/31/2026 reflected that he had ADL self-care performance deficit related to dementia (neurocognitive disorder). Interventions included 1 staff participation with personal hygiene and oral care. A record review of Resident #9's progress notes dated 4/07/2026-5/07/2026 reflected no documented refusals of care. A record review of Resident #34's face sheet dated 5/07/2026 reflected an [AGE] year-old male readmitted on [DATE] with diagnoses of muscle weakness, dementia (neurocognitive disorder), Parkinson's disease (progressive neurological disorder), unspecified lack of coordination, hypertension (high blood pressure), and history of falling. A record review of Resident #34's MDS assessment dated [DATE] reflected that he was not assessed for a BIMS score. A record review of Resident #34's care plan revised on 5/07/2026 reflected that he had ADL self-care performance deficit related to dementia (neurocognitive disease). Interventions included check nail length and trim and clean on bath day and as necessary. During an observation and interview on 5/05/2026 at 2:16 PM, Resident #34 was observed sitting in a wheelchair. Resident #34's nails were observed to have about 3 mm of white showing and there was a dark, unidentifiable substance underneath his nails. Resident #34 stated no his nails were not long for him. A record review of Resident #34's progress notes dated 4/07/2026-5/07/2026 reflected no documented refusals of care. During an observation and interview on 5/05/2026 at 2:36 PM, Resident #9 was observed lying in bed. Resident #9's fingernails had about 4 mm of whites showing. Resident #9 stated no that staff had offered to trim his nails and that he did not have nail clippers. During an interview and observation on 5/07/2026 at 2:15 PM, LVN A stated that CNAs did nail care as needed or daily. LVN A looked at Resident #9's nails and stated that his nails were very long, she did not know when the last time they were trimmed , and that his nails were a little dirty. During an observation and interview on 5/07/2026 at 2:22 PM, LVN A was observed walking into Resident #34's room. LVN A then walked out and stated that Resident #34's nails were very long and on a scale of 0-10, which 10 being the dirtiest, they were a 6. LVN A stated that Resident #9's were a 7 out of 10. During an interview on 5/07/2026 at 4:27 PM, the DON stated that if residents were not diabetic, CNAs could do nail care. The DON stated that nail care was done once a week on Sunday and as needed. The DON stated that she had not seen Resident #9's or Resident #34's nails. When asked how having long nails could impact residents, the DON stated they could scratch themselves and I wouldn't want dirty fingernails [when] eating. During an interview on 5/07/2026 at 4:49 PM, the ADM stated that the nail care policy depended on whether the resident was diabetic and that he did not know whether Resident #9 or Resident #34 were diabetic. The ADM stated, we do get some residents that refuse and said if residents refused nail care, it should be documented in a progress note. When asked how long nails could impact residents, the ADM stated it could lead to bacteria buildup and many things. A record review of the facility's undated policy titled Grooming Care of the Fingernails and Toenails reflected the following: PurposeNail care is given to (continued on next page)

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	455799	A. Building B. Wing	05/07/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean and keep the nails trimmed.PolicyFingernails are trimmed by Certified Nursing Assistants except for residents with the following conditions:A. Diabetes or circulatory impairment of the handsB. Ingrown, infected, or painful nailsC. Nails that are too hard, thick, or difficult to cut easily

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	455799	A. Building B. Wing	05/07/2026

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident received care consistent with professional standards of practice to prevent pressure ulcers for 1 of 8 residents (Resident #97) reviewed for skin assessments. The facility failed to assess Resident #97's skin weekly, as required by the facility's policy, from December 2025 to May 2026 This failure placed residents at risk for unidentified skin issues.Findings included: A record review of Resident #97's face sheet dated 5/07/2026 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of sequelae of cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis), morbid (severe) obesity, and rhabdomyolysis (rapid breakdown of skeletal muscle). A record review of Resident #97's MDS assessment dated [DATE] reflected a BIMS score of 6, which indicated moderately impaired cognition. A record review of Resident #97's care plan dated 5/07/2026 reflected that she had potential for pressure ulcer development related to immobility. A record review of Resident #97's TAR/MAR dated May 2026 reflected an order dated 5/20/2023 for weekly skin assessments every evening shift every Wednesday. There were no orders for barrier cream. A record review of Resident #97's chart on 5/06/2026 reflected that her last skin assessment was on 12/08/2026. A record review of Resident #97's skin assessment dated [DATE] reflected that she did not have any skin impairments. During an observation and interview on 5/05/2026 at 10:23 AM, Resident #97 was observed lying on her back. Resident #97 stated no she did not have any wounds. During an interview on 5/07/2026 at 11:03 AM, RN C stated that Resident #97 was bedbound and most of the time she did not want to be touched. When asked if Resident #97 refused skin assessments, RN C stated, not really. RN C stated that she saw Resident #97's backside about two weeks ago and there wasn't anything. RN C stated, we have weekly skin assessments for patients who are bedbound and for ones who refuse hygiene-I can check if she is one. RN C stated that Resident #97 received barrier cream. During an interview on 5/07/2026 at 9:49 AM, the DON stated that all skin assessments should be under the ?assessments' tab in [the EHR]. The DON stated that skin assessments were done weekly and every resident had a specific day they were supposed to have them. The DON stated the nurse or Wound Care RN did skin assessments. The DON stated that Resident #97 did not have any pressure injuries to her knowledge. When asked how not receiving regular skin assessments could impact Resident #97, the DON stated she could have skin issues we're not aware of. During an interview on 5/07/2026 at 4:49 PM, the ADM stated if the policy said that all residents needed skin assessments weekly, his expectation was to adhere to policy. When asked how Resident #97 could be affected by not receiving regular skin assessments, the ADM stated, she could get a bed sore or pressure ulcer. A record review of the facility's undated policy titled Wound management reflected the following: PurposeTo provide a system for the treatment and management of residents with wounds including pressureand non-pressure injury.ProcedureI. AssessmentA. A Licensed Nurse will perform a skin assessment upon admission, readmission, weekly,and as needed for each resident.