

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 W. Slaughter Lane Austin, TX 78748	
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 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** 42949 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #1) out of three residents reviewed for ADLs, in that: The facility failed to provide showers to Resident #1 in compliance with his shower schedules. This deficient practice placed residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including pressure ulcer of left buttock, major depressive disorder, multiple sclerosis (a potentially disabling disease of the brain and spinal cord) and need for assistance with personal care. Review of Resident #1's quarterly MDS assessment, dated 03/05/24, reflected a BIMS of 15, indicating he had no cognitive impairment. Section GG (Functional Abilities and Goals) reflected he was dependent for showering/bathing. Review of Resident #1's quarterly care plan, dated 02/08/24, reflected he had an ADL self-care performance deficit related to quadriplegia (a form of paralysis that affects all four limbs) with an intervention of requiring assistance (x1) with bathing/showering three days a week and as necessary. Review of Resident #1's shower tasks in his EMR, from 03/01/24 - 03/28/24, reflected he received three showers - 03/15/24, 03/21/24, and 03/26/24. Review of Resident #1's shower sheets, for the month of March 2024, reflected he received a shower on 03/26/24. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/28/24 at 8:42 AM, revealed Resident #1 was lying in his bed watching television. His face was covered in scruffy facial hair. He stated he did receive a shower the previous Tuesday, 03/26/24, but before that he had only gotten two showers that month. He stated on 03/26/24, the aide (could not remember her name) told him she was too busy to shave his face. He stated he hated having hair on his face. He stated he had to basically beg staff to shower him and he constantly felt grimy and gross. During an interview on 03/28/24 at 12:27 PM, the DON stated they had some shower techs that strictly did showers, but if they called in to work, the aides would have to complete the showers. She stated the residents should be showered according to their shower schedule, three times a week. She stated the aides filled out shower sheets and gave them to the SC who ensured showers got done. She stated she was not sure if she had some kind of log to ensure all showers got done on the days they were scheduled. She stated she would expect all shaving needs to be completed along with a shower. She stated a negative outcome of not receiving regular showers could be skin breakdown or open areas. During an interview on 03/28/24 at 12:59 PM, the SC stated she followed-up with the aides throughout the day to see which residents had gotten showers or if any residents had refused. She stated she collected the shower sheets and would put them in the ADON's office. She stated residents should be showered at least three times a week. She stated she was not aware Resident #1 was not getting bathed according to his shower schedule. During an interview on 03/28/24 at 1:06 PM, CNA A stated she was one of the shower aides, but she had been on light duty for a while due to an injury. She stated light duty consisted of answering call lights and passing out meal trays. She stated residents were to be showered at least three times a week. She stated the aides documented showers on shower sheets and in the POC. She stated the aides would give the shower sheets to their nurse at the end of their shift . Review of the facility's CNA Job Description, dated 12/17/21, reflected the following: Position summary: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. Essential Job Duties and Responsibilities: . Assist residents with bath functions (i.e., bed bath, tub, or shower bath, etc.) as directed. Review of an in-service entitled Shower Schedule conducted by the DON, dated 03/06/24, reflected the CNAs were reeducated on the following: Showers need to be given based on shower schedule . Schedule is on both shower rooms and at nurses' station binder . If a shower was not done, please communicate to [SC]. A beds are in AM B beds are in PM (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Nursing Services (ADLs) Policy, revised 05/2007, reflected the following: Nursing services staff cares for its residents in a manner and in an environment that promotes maintenance or enhancement of each residents' quality of life . . Residents receive assistance as needed to manage their physical needs which includes personal hygiene, grooming, dressing, toileting, transferring, ambulating, and eating.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #2) of three residents reviewed for accidents and hazards, in that: The facility failed to ensure Resident #2 (who was a high-elopement risk) did not elope from the facility on 03/26/24 at 12:50 PM when the Receptionist used her remote-control door opener to unlock the front door. He was located over 24 hours later at a bus stop approximately 12 miles from the facility. The noncompliance was identified as PNC. The IJ began on 03/26/24 and ended on 03/27/24. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . Findings included: Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), hypertension (high blood pressure), type II diabetes, and frontal lobe and executive function deficit following cerebral infarction. Review of Resident #2's admission MDS assessment, dated 03/06/24, reflected a BIMS of 11, indicating a moderate cognitive impairment. Section GG (Functional Abilities and Goals) reflected he ambulated independently. Section P (Restraints and Alarms) reflected he required no physical restraints or alarms. Review of Resident #2's admission care plan, dated 02/26/24, reflected he was an elopement risk/wanderer related to impaired safety awareness with an intervention of providing structured activities. Review of Resident #2's Elopement/Wandering Evaluation, dated 02/27/24, reflected he was a high risk for elopement. Review of Resident #2's nursing progress notes, dated 03/26/24 at 7:35 PM and documented by LVN C, reflected the following : [Resident #2] reported missing to charge nurse around 5PM charge nurse was on 200 hall. [Resident #2] is aox2-3 and has a hx of attempting to elope. [Resident #2] usually goes to smoke break at regular intervals. Informed DON, ADMIN, ADON. All staff began searching entire facility for [Resident #2] . police called. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's nursing progress notes, dated 03/27/24 at 9:50 PM and documented by LVN C, reflected the following : [Resident #2] brought back to facility via private vehicle with staff member. No new orders given from hospital . Sitter at bedside. During an interview on 03/28/24 at 9:32 AM with the ADM and DON, the ADM stated around 5:00 PM on 03/26/24, a MA notified the charge nurse that he could not find Resident #2 when he went to administer his medication. The ADM stated upon review of the video footage, Resident #2 attempted to push the front door open around 12:50 PM and the alarm went off. The ADM stated the Receptionist looked up and immediately pressed the button that turns the alarm off and unlocks the door. The ADM stated Resident #2 then pushed open the door and walked out. He stated his expectations were that all staff, including the Receptionist, were to verify residents before allowing them to exit the facility. The ADM stated the Receptionist was fully aware Resident #2 was an elopement risk and he was even in the elopement binder that was kept at the Receptionist's desk and the nurses' station. The ADM stated all residents that were a high risk of wandering/elopeing had their picture in the binder, along with their face sheet, and the elopement process. The ADM stated the Receptionist had been suspended and would not be returning. The ADM stated they had more than 20 people searching for Resident 32 around the clock and he was found at a bus station around 4:22 PM on 03/27/24 by a sister facility's ADM. The ADM stated they took him to the hospital for an evaluation and other than mild dehydration, he had a good bill of health and was taken back to the facility. The ADM stated he did not remember what he did the day before but was now on 1:1 around-the-clock until they found alternate placement. On 03/28/24 at 10:40 AM, a telephone call was made to the Receptionist. A return call was not received prior to exiting. During an observation and interview on 03/28/24 at 11:53 AM, revealed Resident #2 was in his bed sleeping. HSK B was sitting in his room. She stated she worked in the housekeeping department but today was sitting with Resident #2 due to his elopement incident. She stated he had not exhibited any exit-seeking behaviors and when she asked him what he did yesterday (03/27/24), he stated he went to the store for groceries. She stated before her shift she was in-serviced on the elopement policy, exit-seeking behaviors, and about verifying residents in the elopement binders at the front desk and nurses' station before every letting a resident leave. During an interview on 03/28/24 at 11:59 AM, LVN C stated she was in-serviced before working her shift on elopements, the elopement binders, checking the binders if a resident was trying to leave, and ensuring you put eyes on each of their residents at the beginning of their shift, frequently, and end of their shift. During an interview on 03/28/24 at 12:08 PM, the MDSC stated she had been in-serviced the day Resident #2 eloped. She stated the in-services included their elopement policy, the elopement binders, and exit-seeking behaviors. She stated at every morning meeting she was told if someone was a high-elopement risk she was responsible for ensuring their care plan had interventions in place. During an interview on 03/28/24 at 12:59 PM, the SC stated she had been in-serviced on the elopement binders, if a resident was a high-risk of elopement and wanted to go outside, to go out with them and ensure to bring them back inside. She stated she was also in-serviced on redirecting residents that wandered. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/28/24 at 1:06 PM, CNA A stated she was in-serviced before her shift the day before, 03/27/24. She stated the in-services were about elopements, the elopement binder, knowing residents that were a high-risk of eloping, who to notify, and to check on the residents every two hours and ensure you lay eyes on them. During a telephone interview on 03/28/24 at 1:18 PM, CNA D stated she worked on Resident #2's hall on the day he eloped. She stated when she made her initial rounds at 2:00 PM, he was not in his room, but that was not unusual for him because he was rarely in his room as he liked to walk around the facility and sit in the dining room or living room area. She stated she knew she had made a mistake. She stated she had been in-serviced on ensuring they lay your eyes on your residents at the start of each shift and every two hours. She stated there were elopement binders at the front desk and the nurses' stations which identified residents that were high risk. Observation on 03/28/24 from 1:57 PM - 2:04 PM revealed three staff members getting in-serviced by the DON and taking a written elopement quiz in the front lobby before clocking in for their shifts. During an interview on 03/28/24 at 2:08 PM, the new Receptionist stated if a resident wanted to leave the facility, she would first check the elopement binder to ensure they were not a high elopement risk. Review of the facility's Suspension document, dated 03/26/24, reflected the Receptionist was suspended pending the full investigation. Review of the facility's Elopement Timeline for Resident #2, from 03/26/24 - 03/27/24, reflected the following: [Resident #2] (Elopement) 3/26/24 Timeline: 5:15 PM- Med Aide, looked to provide meds to resident and saw they were not in their room. Resident often would sit in other resident's rooms or be in other places of the building, but upon looking for him, it was determined resident may be missing. 5:45 PM- ED and DON were notified that resident was not able to be found after staff had searched the facility and other resident rooms. Immediate code was called to search for the resident. Reviewed Cameras: 12:45 PM- It was observed that [Resident #2] left his room and per his roommate's statement was going to go and purchase or find some cigarettes. 12:50 PM- [Resident #2] approached front door and attempted to open the door. The door alarm sounded, and the resident pulled back from the door. Receptionist looked and noticed someone wanting to exit and pushed the button to release the door alarm and [Resident #2] was able to leave the facility. 6:28 PM- Notified cluster and market to create search party in the local area- reaching out to hospitals, potential places resident may have gone to, metro bus routes were contacted, reached out to point of contacts. POC on file has not had any contact with him and asked that we stop reaching out as he does not want involvement with the resident. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7:10 PM- Police were called after initial search and resident not returned. Case #240861143- Officer [name] #8755. 7:00 PM-11:00 PM- Search parties drove surrounding neighborhoods, called hospitals every couple hours, spoke with local patrons of convenient stores/gas stations/stores providing pictures of the resident. 3/27/24 6:30 AM- Searching began again: 6:30 AM- Local Hospitals called. 7:22 AM- All bus stops from (street) to (street) 7:27 AM- (homeless shelter) searched 7:32 AM- (two major retailers), 2 Homeless [NAME] near (major highway) 8:04 AM- Parks and Churches in area around facility 8:27 AM- Gas stations from (street) to (street) 8:27 AM- (fast-food restaurant) on (intersection) stated they would review their cameras for us this morning 8:34 AM- (apartment complex) just west of the facility 8:38 AM- (neighborhood) east of facility 8:58 AM- (neighborhood) cleared 9:00 AM- (DON from sister facility) contacted (bus) company to ask for any sign on bus routes. From 4PM 3/26 to 4 AM 3/27, there were not sightings of the resident. 9:13 AM- (public park) cleared 9:17 AM- (fast-food restaurant) stated they would review cameras for us and get back to us later 9:47 AM- (neighborhood) 10:20 AM- (grocery store) 10:24 AM- (ED from sister facility) spoke with police department to see if they can trace bank information, they are unable to do that due to time to do that and not being next of kin, but did identify a [family member] that we can try and contact but did not have contact information 11:33 AM- Calls to hospitals and transits again (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:54 AM- (fast-food restaurant) staff member saw the silver alert and would look out 12:07 PM- (transit company) searched as well as (nearby church) 12:15 PM- (grocery store) at (intersection) searched again 12:22 PM- (fast-food restaurant) confirmed they did not see him on Camera 12:23 PM- two gas stations searched 12:35 PM- (three retailers) 12:55 PM- All hospitals called again 1:09 PM- Flyer created based on silver alert to provide to vendors, stations, community 2:00 PM- Huddle with staff- in-serviced staff on Elopement Risk, Elopement Policy, Resident Monitoring and Residents walking along driveway 2:30 PM- Regrouped- Mapped out more regions and sent teams to additional grids of [city name]- some interviewed current residents to see if they would have additional insight to where he may go- one resident made recommendations more into downtown [city name] 3:50 PM- Security company across from facility shared that they had video of resident from prior day heading east towards (major highway) 4:22 PM- [Resident #2] was found at a bus stop- was willing to go with (two EDs from sister facilities), who took him to (hospital) evaluation 4:48 PM- Called Police Department to give update on resident being located 5:23 PM- Submitted Self Report to HHSC 5:30 PM- QAPI Meeting completed with IDT and Medical Director regarding elopement risk, root cause and interventions and next steps 6:00 PM- Present- Continue inservicing staff Review of an in-service entitled Elopement Process, from 03/26/24 - 03/27/24, reflected staff from all shifts were in-serviced on the following: Where are the elopement binders? Who is in the binders? Elopement Policy and Procedure Review of the facility's Interdisciplinary Committee Meeting (QAPI) agenda, dated 03/27/24, reflected the MD, DON, ADM, MDSC, SW, SC, BOM, and other corporate individuals were in attendance. The problem areas discussed reflected the following: (continued on next page)		

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