STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676095	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Nursing and Rehabilitation Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure the residents' right to a dignified existence for 2 of 11 residents reviewed for dignity. 1. The facility failed to ensure that PTA A maintained Resident #1's dignity when speaking with her in a public area. 2. The facility failed to ensure Resident #2's back and incontinence brief area were not exposed in a public area while she waited for a shower. This failure placed residents at risk of embarrassment and diminished quality of life. Findings included: 1. Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (brain damage due to lack of blood and/or oxygen), cognitive communication deficit (difficulty communicating that is caused by a problem with thinking), aphasia (speech difficulties) following cerebral infarction, age-related physical debility, and need for assistance with personal care. Review of the quarterly MDS assessment for Resident #1, dated 02/13/24, reflected a BIMS score of 00, indicating severe cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #1, dated 11/17/22, reflected the following: [Resident #1] is at risk for impaired thought process r/t CVA. Will be able to communicate basic needs on a daily basis through the review date. COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. [Resident #1] has a communication problem r/t CVA and hearing deficit. Will be able to make basic needs known on a daily basis through the review date. Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback/clarification from the resident to ensure understanding,Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and picture. The care plan also reflected the following item: [Resident #1] is taking medication, Chlorophyllin for controlling odor. Nullo is a dietary supplement which customers have found to be effective to reduce personal odors related to body odor, perspiration, incontinence, fecal odor, and adult diaper odor. Observation on 04/10/24 at 11:02 AM revealed PTA A in the 100 hall speaking loudly enough to be heard from another room on the hall. PTA A stated, Do you need some more pull ups? You know, like a diaper that goes on a baby? Do you need more of those? Don't you usually wear those? Upon exiting the other room on the hall, the surveyor observed PTA A was speaking to Resident #1 out in the hallway two doors down from Resident #1's room. During observation and interview on 04/10/24 at 11:25 AM, Resident #1 was in her bathroom tying up a used incontinence brief in a wastebasket bag and tidying her bathroom. She made eye contact and smiled when addressed but did not respond verbally and did not indicate she understood any questions being asked of her. 2. Review of the undated face sheet for Resident #2 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included left-sided hemiplegia and hemiparesis (paralysis of one side of the body), chronic pain syndrome, attention and concentration deficit following cerebral infarction (brain damage due to lack of blood and/or oxygen), need for assistance with personal care, aphasia (speech difficulties) following cerebral infarction, reduced mobility, cognitive communication deficit (difficulty communicating that is caused by a problem with thinking), age-related physical debility, anxiety disorder, and bipolar disorder (a serious mental illness characterized by extreme mood swings). Review of the quarterly MDS assessment for Resident #2, dated 02/22/24, reflected a BIMS score of 10, indicating moderate cognitive impairment. It also reflected Resident #2 required partial/moderate assistance in the activity of bathing and she was independent with ambulation in her wheelchair. Review of the care plan for Resident #2, dated 01/10/23, reflected the following: [Resident #2] has an ADL Self Care Performance Deficit r/t left sided Hemiparesis, debility, and weakness secondary to CVA history. Will maintain current level of function in ADLs through the review date. BATHING: Is able to: wash chest area and prefers to wash part of her hair with her right hand as able, requires total assist to complete bathing of body and washing of hair. DRESSING: Requires extensive staff participation to dress. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/10/24 at 11:04 AM revealed Resident #2 in her wheelchair in front of the shower room in a hospital gown leaning forward to touch something in a shower caddy which was sitting in front of her. PTA A came up behind Resident #2, greeted her, and walked away. Resident #2 leaned forward again to move items in her shower caddy, and her hospital gown was completely open in the back, revealing her naked back, sacral area, and the upper portion of her incontinence brief. During an interview on 04/10/24 at 11:15 AM Resident #2 stated the staff did this to her all the time. She stated she wore the hospital gown to bed, and she would get into clean clothes after her shower, but they often left her sitting in front of the shower room for a long time while she waited to be showered. Resident #2 stated she went to the shower room door herself, but none of the staff cared what state she was in while she sat and waited. Resident #2 stated she did not want the whole hallway of residents and visitors to see her exposed back and brief, but they did not care. During an interview on 04/10/24 at 01:00 PM, PTA A stated she had worked at the facility for a year and had not received any training from the facility specifically about speaking to residents in a way that maintained their dignity. PTA A stated she saw Resident #1 looking in the linen cart the CNAs used and had been trying to figure out if Resident #1 needed a pull-up. PTA A stated Resident #1 had a hard time communicating and was hard of hearing, so sometimes it was difficult to ascertain what she wanted. PTA A stated she had come down the hall to invite residents to a group exercise activity, and she saw Resident #1 out of her room, not using her wheelchair, and was trying to intervene. PTA A stated Resident #1 had a wheelchair but was often noncompliant with it. PTA A stated a possible negative outcome of speaking to a resident the way she did to Resident #1 in a public was the resident might be embarrassed, but PTA A was trying to help Resident #1. PTA A stated Resident #2 was always anxious about her showers and often waited outside the shower room on those days. PTA A stated she had just stopped to say hello to Resident #2 and did not really notice she was exposed. During an interview on 04/10/24 at 02:58 PM, the DON stated they included the therapy staff in in-services about some topics, and she thought the therapists would have participated in trainings about Resident Rights. The DON stated she was not sure who was responsible for ensuring the therapists and therapy assistants spoke to residents in a way that maintained their dignity. The DON stated she would not like to be spoken to the way PTA A spoke to Resident #1 in the hall, and it also may have been a HIPAA violation. The DON stated she would not like everyone to know she wore a brief or a pull up. The DON stated Resident #2 often waited outside the shower room because she felt like she would not get a shower and she took a whole hour for her shower. The DON stated Resident #2 usually wore a hospital gown while sitting outside the shower room, and that was her choice. The DON stated she did not know if that had been care planned. The DON stated they had talked to Resident #2 about her back and brief being exposed, but Resident #2 did not like to be told anything. The DON stated the staff could have offered to cover her up. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 04:04 PM, the ADM stated he monitored to ensure that residents are treated with dignity by having weekly huddles and talking about customer service. He stated facility staff needed to treat residents like they were valued people who had earned the right to be respected at this point in their lives. The ADM stated PTA A told the DOR what had happened with Resident #1, but he had not heard she said anything about wearing diapers like a baby. He stated that was not the way they should have ever spoken to residents. He stated if they needed to be that direct with residents about incontinence, it needed to happen privately, inside the resident's room. The ADM stated Resident #2 was adamant about her shower time and was willing to come and wait by the shower door for a long time. The ADM stated he had not witnessed her sitting in an open gown and hoped someone would have covered her back for her. He stated he did not want her to have to be exposed in the hall, and they would need to find a solution. A policy on Resident Rights was requested from the ADM, but the policy provided was for Notice of Resident Rights and Responsibilities and did not contain any information pertinent to the above failure.

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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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 4 residents (Resident #3 reviewed for pain management. The facility failed to ensure Resident #3 received his 08:00 AM scheduled Norco on time for 7 of 10 days between 04/01/24 and 04/10/24. This failure placed residents at risk of increased pain and decreased quality of life. Findings included: Review of the undated face sheet for Resident #3 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included multiple sclerosis , chronic pain syndrome, muscle weakness, stage 4 pressure ulcer of left buttock, major depressive disorder, and high blood pressure. Review of the quarterly MDS assessment for Resident #3, dated 03/05/24, reflected a BIMS score of 15, indicating intact cognition. It also reflected Resident # 1 was completely dependent on a helper to execute all ADLs, including bed mobility, transfer, dressing, eating, ambulation, bathing, and personal hygiene. It reflected that he received a scheduled regimen for pain, received non-pharmacological interventions for pain, had experienced pain in the five days leading up to the assessment, and was taking an opioid medication for pain. Review of the care plan for Resident #3, dated 02/08/24, reflected the following: is at risk for pain r/t disease process. Will voice a level of comfort of through the review date. Able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain) . Follow pain scale to medicate as ordered. Pain assessment every shift. Therapy evaluation and treatment per physician orders. Review of physician orders for Resident #3 on 04/10/24 reflected the following: Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times a day for chronic pain related to MULTIPLE SCLEROSIS with a start date of 02/01/24. Administration times were listed as 12:00 AM (midnight), 04:00 AM, 08:00 AM, 12:00 PM (noon), 04:00 PM, and 08:00 PM. Baclofen Oral Tablet (Baclofen) Give 20 mg by mouth five times a day for muscle relaxant related to MULTIPLE SCLEROSIS with a start date of 02/01/24 and administration times of 04:00 AM, 08:00 AM, 12:00 PM (noon), 04:00 PM, and 08:00 PM. Review of the April 2024 MAR for Resident #3 reflected the following administration times: 04/01/24 Norco administered at 09:32 AM; Baclofen administered at 09:39 AM 04/04/24 Norco administered at 09:13 AM; Baclofen administered at 09:12 AM (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	04/05/24 Norco administered at 09:42 AM; Baclofen administered at 09:42 AM 04/06/24 Norco administered at 09:59 AM; Baclofen administered at 09:59 AM 04/07/24 Norco administered at 09:36 AM; Baclofen administered at 09:35 AM 04/08/24 Norco administered at 09:23 AM; Baclofen administered at 09:23 AM 04/10/24 Norco administered at 09:25 AM; Baclofen administered at 09:24 AM Review of pain assessments (0-10 scale, with zero being the least amount of pain and 10 the most) for Resident #3 reflected 0 for each day shift from 04/01/24 to 04/07/24 and 04/09/24 and a level 6 on 04/08/24. Observation and interview on 04/10/24 at 11:53 AM revealed Resident #3 lying flat in his bed with his overbed table pushed up over his chest and a flosser he placed his teeth and used to press television remote buttons . Resident #3 stated he was scared to death that the facility would take his medications away from him, and every morning when he waited for his morning dose of Norco, he became even more scared. Resident #3 stated he took Norco every four hours, and he stayed up at night, because he was afraid if he went to sleep, he would not get his morning Norco on time. Resident #3 stated his 08:00 AM administration was late every day, and that was why he was scared. He stated he always had pain even with his Norco, but he needed his medication on time to stay on top of the worst of the pain. During an interview on 04/10/24 at 02:33 PM, MA B stated she passed medications to Resident #3 five days a week. She stated she had been slower than usual, and she did not know exactly why. MA B stated the documentation times in the MAR audit were correct, and she did give the morning meds to Resident #3 late often. MA B stated she was trained to pass medications one hour before or one hour after their administration times. MA B stated she was used to passing medications to a lot of residents and had come from a different facility that had more residents, so the problem was not that she had too much work to do to get it all done. She stated she was occasionally asked to help with things other than passing medications, like getting water, changing the television channel, or putting a blanket over a resident. MA B stated Resident #3 had not complained to her about getting his medication late. MA B stated Resident #3 was always awake in the morning when his medications were due, but he had not said anything about it. She stated he was sometimes in some pain throughout the day, but she did not think it was because his medications were given late, and she had never seen him in a lot of pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 04/10/24 at 02:58 PM, the DON stated the entire nurse management team was responsible for overseeing the medication administration system to ensure that medications were given on time. She stated she had not looked at the medication audit sheet for Resident #3 since the surveyor requested to view it, so she was not aware of any late administrations for him. She stated Resident #3 was very aware of when he should have received his medication, especially his Norco. She stated he usually woke up to get each of his doses even when he was sleeping. The DON stated the policy on how late a scheduled medication could be administered was one hour before to one hour after it was scheduled. The DON stated she would have to investigate why the medication aides were administering the 08:00 AM doses so late. The DON stated Resident #3 should not have gone so long without his morning dose of Norco. She stated he was able to voice if he was in pain, so the potential outcome of intolerable pain was unlikely. The DON stated she was not aware of any grievances filed by Resident #3 or complaints about getting his morning Norco late. The DON stated they obviously had to put a system into place to ensure the medications were not administered late. During an interview on 04/10/24 at 04:04 PM, the ADM stated the DON was the ultimate person responsible for ensuring medications are administered on time according to policy and regulations. He stated she delegated some of those tasks to ADONs, but he was not sure exactly what the details were. The ADM stated he knew they did audits on the MARs and TAR s, and he had been privy to the DON pulling the reports and talking through things on occasion and had participated in conversations after the fact but had not participated in the actual auditing process. The ADM stated Resident #3 had multiple grievances, but none of them were about medication, and the ADM was not aware of any issue with pain management. The ADM stated a potential negative outcome of not receiving scheduled pain medication in a timely manner was not only the possibility of breakthrough pain, but just generally having a poor experience in the facility. The ADM said the failure could also bring about other health conditions due to the stress and anxiety of not receiving his medication on time. Review of facility policy, dated 07/17, and titled Recognition and Management of Pain reflected the following: It is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #3 reviewed for medication administration. The facility failed to ensure Resident #3 received his 08:00 AM medications (Norco, Baclofen, Cozaar, and Cipro) on time for 7 of 10 days between 04/01/24 and 04/10/24. This failure placed residents at risk of not receiving the therapeutic benefit of their medications. Findings included : Review of the undated face sheet for Resident #3 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included multiple sclerosis, chronic pain syndrome, muscle weakness, stage 4 pressure ulcer of left buttock, major depressive disorder, and high blood pressure. Review of the quarterly MDS assessment for Resident #3, dated 03/05/24, reflected a BIMS score of 15, indicating intact cognition. It also reflected Resident # 1 was completely dependent on a helper to execute all ADLs, including bed mobility, transfer, dressing, eating, ambulation, bathing, and personal hygiene. It reflected that he received a scheduled regimen for pain, received non-pharmacological interventions for pain, had experienced pain in the five days leading up to the assessment, and was taking an opioid medication for pain. Review of the care plan for Resident #3, dated 02/08/24, reflected the following: is at risk for pain r/t disease process. Will voice a level of comfort of through the review date. Able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain). Follow pain scale to medicate as ordered. Pain assessment every shift. Therapy evaluation and treatment per physician orders. Review of physician orders for Resident #3 on 04/10/24 reflected the following: Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times a day for chronic pain related to MULTIPLE SCLEROSIS (G35) with a start date of 02/01/24. Administration times were listed as 12:00 AM (midnight), 04:00 AM, 08:00 AM, 12:00 PM (noon), 04:00 PM, and 08:00 PM. Cozaar Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for HTN hold for SBP <110 or HR <60 bpm with a start date of 02/02/24 and administration time 08:00 AM Baclofen Oral Tablet (Baclofen) Give 20 mg by mouth five times a day for muscle relaxant related to MULTIPLE SCLEROSIS (G35) with a start date of 02/01/24 and administration times of 04:00 AM, 08:00 AM, 12:00 PM (noon), 04:00 PM, and 08:00 PM. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Some	Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for infection for 7 Days with a start date 04/05/2024 and administration times at 08:00 AM and 02:00 PM Review of the April 2024 MAR for Resident #3 reflected the following administration times: 04/01/24 Norco administered at 09:32 AM; Baclofen administered at 09:39 AM; Cozaar administered at 09:39 AM 04/04/24 Norco administered at 09:13 AM; Baclofen administered at 09:12 AM; Cozaar administered at 09:12 AM 04/05/24 Norco administered at 09:42 AM; Baclofen administered at 09:42 AM; Cozaar administered at 09:42 AM 04/06/24 Norco administered at 09:59 AM; Baclofen administered at 09:59 AM; Cozaar administered at 09:59 AM; Cipro administered at 11:53 AM 04/07/24 Norco administered at 09:36 AM; Baclofen administered at 09:35 AM; Cozaar administered at 09:36 AM; Cipro administered at 09:35 AM 04/08/24 Norco administered at 09:23 AM; Baclofen administered at 09:23 AM; Cozaar administered at 09:27 AM; Cipro administered at 09:23 AM 04/10/24 Norco administered at 09:25 AM; Baclofen administered at 09:24 AM; Cozaar administered at 09:25 AM; Cipro administered at 09:25 AM Observation and interview on 04/10/24 at 11:53 AM revealed Resident #3 lying flat in his bed with his overbed table pushed up over his chest and a flosser he placed his teeth and used to press television remote buttons. Resident #1 stated he was scared to death that the facility would take his medications away from him, and every morning when he waited for his morning dose of Norco, he became even more scared. Resident #3 stated he took Norco every four hours, and he stayed up at night, because he was afraid if he went to sleep, he would not get his morning Norco on time. Resident #3 stated his 08:00 AM administration was late every day, and that was why he was scared. He stated he always had pain even with his Norco, but he needed his medication on time to stay on top of the worst of the pain. Resident #3 stated all his morning medications were late, not just the pain medications. During an interview on 04/10/24 at 02:33 PM, MA B stated she passed medications to Resident #3 five days a week. She stated she had been slower than usual, and she did not know exactly why. MA B stated the documentation times in the MAR audit were correct, and she did give the morning meds to Resident #3 late often. MA B stated she was trained to pass medications one hour before or one hour after their administration times. MA B stated she was used to passing medications to a lot of residents and had come from a different facility that had more residents, so the problem was not that she had too much work to do to get it all done. She stated she was occasionally asked to help with things other than passing medications, like getting water, changing the television channel, or putting a blanket over a resident. MA B stated Resident #3 had not complained to her about getting his medication late. MA B stated Resident #1 was always awake in the morning when his medications were due, but he had not said anything about it. (continued on next page)

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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 0755 Level of Harm - Actual harm Residents Affected - Some	During an interview on 04/10/24 at 02:58 PM, the DON stated the entire nurse management team was responsible for overseeing the medication administration system to ensure that medications were given on time. She stated she had not looked at the medication audit sheet for Resident #3 since the surveyor requested to view it, so she was not aware of any late administrations for him. She stated Resident #3 was very aware of when he should have received his medication, especially his Norco. She stated he usually woke up to get each of his doses even when he was sleeping. The DON stated the policy on how late a scheduled medication could be administered was one hour before to one hour after it was scheduled. The DON stated she would have to investigate why the medication aides were administering the 08:00 AM doses so late. The DON stated Resident #1 should not have gone so long without his morning dose of Norco. She stated he was able to voice if he was in pain, so the potential outcome of intolerable pain was unlikely. The DON stated she was not aware of any grievances filed by Resident #1 or complaints about getting his morning medications late. The DON stated they obviously had to put a system into place to ensure the medications were administered on time. During an interview on 04/10/24 at 04:04 PM, the ADM stated the DON was the ultimate person responsible for ensuring medications are administered on time according to policy and regulations. He stated she delegated some of those tasks to ADONs, but he was not sure exactly what the details were. The ADM stated he knew they did audits on the MARs and TARs, and he had been privy to the DON pulling the reports and talking through things on occasion and had participated in conversations after the fact but had not participated in the actual auditing process. The ADM stated Resident #3 had multiple grievances, but none of them were about medication, and the ADM was not aware of any issue with pain management. The ADM stated a potential negative outcome of not receiving scheduled pain medication in a timely manner was not only the possibility of breakthrough pain, but just generally having a poor experience in the facility. The ADM the failure could also bring about other health conditions due to the stress and anxiety of not receiving his medication on time. A policy on medication administration times was requested from the ADM but not provided prior to exit.