STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676271	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onion Creek Nursing and Rehabilitation Center	1700 Onion Creek Pkwy 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) of five residents reviewed for care plans, in that: The facility failed to care plan Resident #1's history of refusal of care and medication from 01/02/2025 to present. This failure placed residents at risk of not receiving goals and interventions for the residents' individual needs for person-centered care. Findings included: Review of Resident #1's face sheet dated 06/30/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (a patient has a pre-existing chronic heart failure condition that suddenly worsens due to both systolic (the pressure in your arteries when your heart contracts and pumps blood out to the body) and diastolic (the pressure in the arteries when the heart is at rest between beats) dysfunction, vascular dementia (damage to the brain's blood vessels impairs cognitive functions, leading to memory, thinking, and behavioral changes) and cognitive communication deficit (communication difficulties stemming from impairments in cognitive processes like attention, memory, and reasoning, rather than primary language or speech problems). Review of Resident #1's quarterly MDS assessment, dated 04/27/25, reflected a BIMS score of 3, indicating severe cognitive impairment. [BR1] [TN2] Review of Resident #1’s Nurse Progress Note (identity of nurse unknown) dated 1/2/2025 reflected nurse attempted to assess resident's weight; resident refused. Nurse attempted three times with no success. Review of Resident #1’s Nurse Progress Note by LVN A dated 03/30/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/03/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1’s Nurse Progress Note by LVN A dated 04/05/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/09/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/10/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/11/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/15/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/16/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 04/16/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/03/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/04/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/05/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/09/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/10/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/15/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note by LVN A dated 05/21/25 eMAR Medication Administration Note reflected Resident #1 refused her medication. Review of Resident #1’s Nurse Progress Note (identity of nurse unknown) dated 05/26/25 reflected Resident #1 refused shower and bed bath this evening. Review of Resident #1’s Nurse Progress Note (identity of nurse unknown) dated 06/09/25 reflected Resident #1 refused shower when asked by CNA and nurse and refused bed bath. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan reflected no identified focus, goals, or interventions/tasks for her history of refusal of care and medication. Interview on 06/30/25 at 3:42 pm with the Wound Care Nurse revealed he had witnessed Resident #1 being resistant to resident care, but she had not refused care when he had offered wound care. He said a combination of people were responsible for care plans. He said the MDS Coordinator was not the only person responsible for care plans. He said the care plan was a structured plan geared to a specific outcome with intentional interventions. He said it was important to know if a resident had care refusal because it would change the approach that needed to be taken for resident care. Interview on 06/30/25 at 3:58 pm with the MDS Coordinator reflected, after she reviewed Resident #1’s care plan, that Resident #1’s care plan did not include medication or shower refusals and said the refusals should be included in the care plan. She said the MDS coordinator was ultimately responsible for the care plan, but it was a group effort because she was not a floor nurse, and she had to rely on the information that had been discussed in morning clinical meetings to update the care plan. She said she did not recall that the staff had discussed Resident #1’s history of medication or shower refusals in morning clinical meetings. She said every nurse in the building had access to the care plans and the ability to update the care plan. She said a care plan was in place for everybody to know the status of where residents were and what care they needed. She said if something was not care planned, staff would not know all aspects of a residents care. She said resident refusals for showers and medication were important because if the resident was developing sores or a rash the facility would know why and would be able to notify the MD about what was going on. She said that care plans included interventions that assisted with resident care. Interview on 06/30/25 at 5:19 pm with LVN A revealed he regularly administered Resident #1 her medications and she had a history of refusing medication at least 50% of the time and additionally, she refused showers. He said the care plan was needed for any resident issues, concerns, and solutions. The care plan was in place to prevent resident issues or have a plan to, overtime, solve resident issues. He said the DON was responsible for care plans and he thought care plans were definitely important because they were a reminder to the staff of the care that they give to the residents. He said he thought including resident refusal of medications and care were important to add to the care plan so the nurse was up to date and could keep track of if the resident improved or did not improve. He said the negative affect of not included medication and care refusals in the resident care plan was if the resident was refusing medication, health issues the resident was having were not being addressed. He said because he worked in the evenings and did not attend staff morning meetings, but he believed that the DON had been told about Resident #1 refusing medication and showers. Interview on 06/30/25 at 4:30 pm with LVN B revealed she worked with Resident #1 and Resident #1 refused showers. She said the purpose of a care plan was to know how to care for a resident step by step. She said it was a plan for care. She said that resident refusals should be care planned because it was important to know what to do when a resident refused care. She said the interventions in a care plan could help to solve a problem with a resident. She said nurses were responsible for care plans and Resident #1’s refusals of showers had been discussed in the morning clinical meetings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/03/25 at 4:02 pm with the Administrator revealed a care plan was an assessment that painted a picture of the resident and the MDS Coordinator was responsible for the care plans. It was the responsibility of the floor nurses to inform the MDS Coordinator about Resident #1’s shower and medication refusals at the morning clinical meeting. She said she did not know until recently that Resident #1 refused care and said refusal of care should be care planned. She said you would want refusals of shower and medications to be care planned because you would want everyone to be aware of the refusals. She said there could be possible interventions for refusals that could help. Care plans are needed because they were important to patient centered care. She said ultimately the DON was responsible for making sure the care plans were person centered and completed. Interview on 07/03/25 at 5:56 pm with the DON reflected she was not previously aware that Resident #1 had a history of refusals of showers and medications. She said a care plan was in place because it let the facility know the things that you needed to do for the resident. She said the DON and the MDS Coordinator were responsible for the care plans. She said the Resident #1’s refusals of medication and shower should have been discussed at morning clinical meeting. She said a possible negative affect of not care planning Resident #1’s refusals of medications and showers was that other staff did not know she had a history of refusing her medication and her showers. Review of facility policy Comprehensive Person-Centered Care Planning dated December 2023 reflected it was the policy of this facility that the interdisciplinary team shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and time frames to meet a residents medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident goal refers to the resident’s desired outcomes and preferences for admission, which guide decision making during care planning. Interventions are actions, treatments, procedures, or activities designed to meet an objective. Measurable is the ability to be evaluated or quantified. Objective is a statement describing the results to be achieved to meet the resident’s goals. Person centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received proper treatment to maintain vision abilities by not assisting the resident in making appointments for 1 of 20 residents (Resident #1) reviewed for vision. The facility failed to address Resident #1's glasses and vision issues, first requested by Resident #1's family via email in March of 2025. Resident #1 did not corrective lenses to assist her vision. This deficient practice could affect residents who need vision and hearing services and could result in avoidable vision loss and a decreased quality of life. Findings included: Review of Resident #1's face sheet dated 06/30/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (a patient has a pre-existing chronic heart failure condition that suddenly worsens due to both systolic (the pressure in your arteries when your heart contracts and pumps blood out to the body) and diastolic (the pressure in the arteries when the heart is at rest between beats) dysfunction, vascular dementia (damage to the brain's blood vessels impairs cognitive functions, leading to memory, thinking, and behavioral changes) and cognitive communication deficit (communication difficulties stemming from impairments in cognitive processes like attention, memory, and reasoning, rather than primary language or speech problems). Review of Resident #1's quarterly MDS assessment, dated 04/27/25, reflected a BIMS score of 3, indicating severe cognitive impairment. Review of Hearing, Speech, and Vision Section B 1000 reflected vision adequate in light (with glasses or other visual appliances) and Section B1200 Hearing, Speech, and Vision reflected corrective lenses (contacts, glasses, or magnifying glass) used, No. Review of Resident #1's care plan reflected focus dated 01/26/24 revealed the resident was at risk for impaired visual function, goal dated 01/26/24 and revised on 12/18/24. The goal reflected Resident #1 will use appropriate visual devices to promote participation in ADL’s and other activities. Interventions dated 01/26/24 reflected arrange consultation with eye care practitioner as required, remind resident to wear glasses when up. Review of an email sent to a facility staff, 1st FFE, from Resident #1’s family member dated 03/05/25 reflected, “Do you know how we would go about getting my [Resident #1’s] glasses fixed? They are very loose and need some adjusting because they keep falling off. Is there someone that comes to do this?” Review of an email sent from a facility staff member, 1st FFE, to Resident #1’s family member dated 03/06/25 reflected, “There is an optometrist that visits. I’ll call and see if they make adjustments in house or send out the glasses to a lab and get back with you.” Review of a email sent to a facility staff, 1st FFE, from Resident #1’s family member dated 03/17/25 reflected, “I was just writing to follow up regarding the glasses and when we might be able to have someone take a look at them.” (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email sent from Resident #1’s family member to AA dated 03/18/25 reflected, “Hi [AA] I had been in correspondence with [1st FFE] at the beginning of the month to try and get [Resident #1’s] glasses fixed and an eye exam. I sent an email to follow up yesterday and got the reply that [1st FFE] was no longer with [facility name]. I just wanted to touch base with someone to see if she was able to contact the visiting optometrist, or what the next steps would be. Unfortunately, her glasses are falling off and are in need of adjustment. “ Review of an email sent from AA to Resident #1’s family member dated 03/18/25 reflected, “I will let you know when her appointment is made.” Review of an email sent from Resident #1’s family member to AA dated 03/25/25 reflected, “I was just following up on the eye appointment for my [Resident #1] to fix her glasses and to get an exam. Has her appointment been made yet?” Review of an email sent from Resident #1’s family member to 2nd FFE and cc’d AA dated 04/07/25 reflected, “I wanted to let someone know that one of the lenses in my [Resident #1’s] glasses fell out due to one of the screws coming out. We found them on her rolling tray today, and I tried looking for the screw but had no luck finding it. Were there any updates regarding her appointment with the optometrist? We left her glasses and the lense on top of her tall dresser.” Review of an email sent from Resident #1’s family member to AA and cc’d to the facility Administrator dated 04/30/25 reflected, “I was writing again to follow up on my [Resident #1’s] optometrist/dental appointments. Her glasses have been missing since Saturday, and no one knows where they are. We searched her room and couldn’t find them.” Review of an email sent from Resident #1’s family member to SW dated 06/09/25 reflected, “I was just following up to see if the optometrist was able to see my [Resident #1] last week or if there’s a pending visit.” Review of an email sent from SW to Resident #1’s family member dated 06/09/25 reflected, “I have recently reached out to the optometrist asking if there would be a visit soon. What I have just found out is they need 20 people minimum to be seen otherwise they can’t see folks. I’ve asked them to see if they can make an exception and I’m waiting on their response. This was definitely news to me to say the least.” Review of an email sent from Resident #1’s family member to SW dated 06/17/25 reflected, “I just wanted to follow up about the optometrist appointment and if they ever got back to you.” Review of an email sent from Resident #1’s family member to SW dated 06/18/25 reflected, “I wanted to see if I could get the name of the optometrist who visits the facility. If we cannot get her seen at [facility name], then our family will need to figure out another way to get her an eye exam and a new set of glasses. We’ve been trying since the beginning of March to get her glasses fixed, and now they’re lost and need to be replaced. She has not had an eye exam or dental exam since she was admitted in November of 2023.” (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email sent from SW to Resident #1’s family member dated 06/19/25 reflected, “I’ve tried to escalate request to [provider name], our optometry provider as they keep saying they need 20 patients on the roster before they can come out. They came the week I started so I’m not sure what changed. I included [the Administrator] to see what options we may have as I know [Resident #1] has vision needs.” Attempted interview on 06/30/25 at 6:00 pm with Resident #1 revealed the resident was not interviewable. Interview on 07/03/25 at 4:14 pm with the SW revealed she had been working as the facility social worker for 2 months and prior to her, they did not have a social worker. The SW said Resident #1’s family had kept asking for Resident #1’s glasses issue to be addressed and it was rather urgent. The SW wore glasses and said she understood it was miserable if people did not have their glasses. She said the last time the optometry provider was at the facility was when she was hired, and the provider will not come to the facility unless there are 20 residents who need optometry assistance. She said Resident #1 was on the list to be seen when the optometry provider comes to the facility. Interview on 07/03/25 at 4:02 pm with the Administrator revealed Resident #1’s family had discussed Resident #1’s glasses situation since April of 2025. Resident #1 was currently on the list with other residents to be seen when the optometrist comes to the facility. The Administrator said the facility had not had a social worker for a while and that was who would normally handle optometry and glasses issues. Resident #1’s family member sent an email to the former AA about the glasses then the AA quit. The ADON was asked to take care of Resident #1’s glasses needs and the ADON stopped working at the facility. Sometime in the middle of May 2025 Resident #1’s glasses needs were discussed during the morning clinical meeting. The Administrator said she understood that Resident #1’s family took her glasses to be repaired because they were broken but she was not aware if the glasses were returned. She said with the staff turnover, Resident #1’s glasses issues were not addressed. She said it was the responsibility of the Administrator and the DON to make sure residents have their glasses. She said if you were already confused, Resident #1 had dementia, you would be more confused and frustrated if you did not have your glasses.