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	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onion Creek Nursing and Rehabilitation Center	1700 Onion Creek Pkwy Austin, TX 78748

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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 - Some	Keep residents' personal and medical records private and confidential. 49097 Based on observation, interview, and record review the facility failed to ensure personal privacy for residents during care by two (Resident #298, Resident #73) of seven resident reviewed for privacy. The facility failed to ensure that MDS B, LVN C, CNA G and CNA H, CNA J knocked/announced themselves before entering Resident #298 and #73's rooms. This failure puts all residents at risk of not having their privacy respected by staff. The findings were: Observation of CNA H at 02/27/2024 at 9:00am walking in resident 73's room without knocking or announcing herself when offering the resident water. Interview with Resident #73 on 02/27/2024 at 10:20am revealed that staff treat him with respect most of the time. He did not answer questions about staff knocking on door. Interview with Resident #298 on 02/27/2024 at 10:25am revealed that staff treat her with respect most of the time. She stated she can not hear if someone knocks or not. Observation LVN C on 02/27/2024 at 3:00pm revealed LVN C walking into several resident 298's room without knocking or announcing himself to the resident. Observation of CNA J on 02/28/2024 at 12:45pm revealed CNA J walking in residents' room taking lunch trays without knocking or announcing herself. Observation of MDS B on 02/28/2024 at 2:00pm revealed MDS B walking in residents' room without knocking or announcing herself to the resident before entering the room. Observation of CNA G on 02/28/2024 at 2:45pm revealed CNA G walking in residents' rooms without knocking or announcing herself before entering. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the MDS B on 02/29/2024 at 9:09am revealed that she had been trained on resident privacy. She stated when going to a resident's room staff are supposed to knock and announce themselves. She stated if staff do not knock and announce themselves residents may feel like staff do not respect them. She also stated that resident's may not feel like it was their home. MDS B revealed that the policy was to abide by the rules and treat as if it was the resident's home. She did not know why she did not knock on resident's door before going in. Interview with CNA H on 02/29/2024 at 9:14am revealed that she had been trained on resident rights and privacy. She stated that when going into a resident's room staff are supposed to knock and announce themselves. She stated she did not know what the policy was on knocking before entering a resident's room. CNA H also revealed when you do not knock on a resident's door, they do not know who ahead of time who is at the door. She stated it is important to let the resident know who is coming in. She stated that she forgot to knock before going into residents' rooms. Interview with CNA J on 02/29/2024 at 9:20am revealed that she had been trained on resident rights and privacy. She stated staff are supposed to knock on the door and announce themselves before entering. She stated that it was important to knock because if staff don't, they could scare the resident and cause a resident to fall. She stated it is their home and should knock before entering. CNA J stated she did not knock because resident verbally told her he needed help, and he was close to the door. Interview with CNA G on 02/29/2024 at 9:26am revealed she has been trained on resident rights and privacy. She stated staff are supposed to knock and tell the resident who they are. She stated that its important to knock so the resident will feel respected, and to give the resident privacy. CNA G stated she forgot to knock on the door and just wanted to check on the residents and see if they needed anything. Interview with the Administrator on 02/29/2024 at 3:06pm revealed staff are to knock on the door and announce themselves to the resident. She stated it is important because the facility is their home, and it would be like just walking into someone's house without knocking. The Administrator revealed if staff do not knock and announce themselves it could make the resident uncomfortable, could affect the quality of care and make the residents feel like staff are invading their privacy. Interview with the DON on 02/29/2024 at 3:13pm revealed staff are supposed to knock on resident's door before entering and announce themselves to the resident. She stated it is important to knock on the door, so the residents have a homelike environment. She revealed if staff are not knocking on the doors before entering and announcing themselves residents could get their feelings hurt and make them feel like the facility is not their home. Record Review of Resident Rights: Dignity and Respect Policy undated revealed staff members shall knock before entering the resident's room. (Knock is in bold).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review the facility failed to have an assessment that accurately reflected the status for 2 of 3 Residents (Resident #96 and Resident #97) reviewed for assessment accuracy in that: 1. Resident #96's discharge MDS dated [DATE] reflected she was discharged to Short Term General Hospital (acute hospital) when she was discharged home. 2. Resident #97's discharge MDS dated [DATE] reflected he was discharged home when he was discharged to Short Term General Hospital (acute hospital). This failure could place residents at risk of not receiving the proper care and services due to inaccurate records. Findings include: 1. Record review of Resident #96's Face Sheet dated 02/29/24 revealed a [AGE] year-old woman admitted to the facility on [DATE] with a diagnosis of muscle wasting and atrophy (decrease in the size of a tissue or organ due to cellular shrinkage)- not elsewhere classified- multiple sites, chronic kidney disease stage 3A (condition in which the kidneys are damaged and cannot filter blood as well as they should), epilepsy- unspecified- not intractable- without epilepticus (a disorder in which nerve cell activity in the brain is disturbed causing seizures), lymphedema- not elsewhere classified (swelling of body part caused by a lymphatic system blockage), hyperlipidemia- unspecified (condition in which there are high levels of fat particles in the blood), and dysphagia- oropharyngeal phase (difficulty swallowing). Record review of Resident #96's discharge MDS dated [DATE], Section A- Discharge Status reflected she was discharged from the facility on 12/01/2023 to Short- Term General Hospital (acute hospital). Section A of Resident #96's MDS reflected was completed by and signed for by MDS A on 12/08/23. Record review of nursing progress notes dated 12/01/23 revealed a nursing discharge note that said, Planned discharge date : 12/01/23. Resident stated she wanted to leave the facility. Family member at her bedside asked charge nurse to get her medications ready because they were going to leave. Called Dr. and doctor talked on the phone with the resident and her family member. Family member stated we have already made our mind up we are going home. Doctor told charge nurse to go ahead and give them their medicines and to discharge them AMA. family member and Resident #96 signed the AMA form and left in their car approximately 8pm. left AMA 12/1/23. In an interview on 02/29/24 at 11:51 AM with Resident #96's family member, he stated that on 12/01/23 the resident decided she no longer wanted to be at the facility because she felt she was not receiving the care she needed. He stated that they made the decision to leave the same day on 12/01/23 and he took her (Resident #96) home. He stated she was not sent to the hospital from the facility upon discharge. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #97's Face Sheet dated 02/29/24 revealed a [AGE] year-old male admitted on [DATE] with a diagnosis of flaccid neuropathic bladder- not elsewhere classified (condition where the bladder does not contract), secondary malignant neoplasm of liver and intrahepatic bile duct (cancer of the cells in the liver), hereditary and idiopathic neuropathy- unspecified (results when nerve damage interferes with the functioning of the peripheral nervous system- and idiopathic when the cause can't be determined), hemoptysis (coughing up blood), and hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone) reflecting a discharge date of [DATE] to Acute Care Hospital: St. David's South [NAME] Medical Center. Record review of Resident #97's discharge MDS dated [DATE] reflected section A2105 with a discharge date of [DATE] to home. MDS reflected section A2105 discharge status was completed and signed by MDS A 12/13/23. Record review of a nursing progress note dated 12/06/23 reflected, Call placed to family member and first contact notified of new order for paracentesis STAT and PET Scan STAT and resident will be taken to SAMC for Paracentesis, by our driver and will be transported back when procedure is complete. Will follow up with any orders or changes upon return. Record review of a nursing progress note dated 12/07/23 reflected, Spoke with family member to get updates on patient. He went out for paracentesis and ended up staying and being admitted to hospital for bronchitis and is now started on antibiotics. Family member stated she will call if she has any further updates. An interview and observation on 02/29/24 at 12:20 PM with MDS A revealed she was familiar with both Resident #96 and #97's care. She stated it is the MDS coordinators responsibility to ensure completeness and accuracy of residents MDS assessments. MDS A stated Resident #96 was discharged on [DATE] AMA and left with her family member and was not hospitalized . MDS A also stated Resident #97 was not discharged home and was in fact discharged to acute care hospital to St. David's [NAME] Medical Center. MDS A was then observed reviewing both Resident #96 and #97's discharge MDS assessments and relevant notes and creating a revised corrected discharge MDS for both residents. An interview on 02/29/24 at 03:00 PM with the DON revealed it is the MDS coordinators responsibility to complete the residents MDS assessments. She stated it is her expectation that they are accurate and that a potential negative outcome to an inaccurate MDS could vary depending on the section that is inaccurate but that it could affect payments as well as care plans. An interview on 02/29/24 at 03:11 PM with the Administrator revealed that it is her expectation that residents MDS assessments are completed accurately and on time. She said that it is the MDS coordinator and the DON's responsibility to verify for completeness and accuracy. The Administrator said that an inaccurate MDS assessment would mean those who have access to it would be receiving incorrect information and that a negative outcome of the MDS being inaccurate is that it could affect the residents care and quality of life. She said it could affect different things depending on what section was entered incorrectly. Record review of Resident Assessment and Associated Processes last revised 01/2022 reflected: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility that residents will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized, reproducible assessments of each resident An accurate comprehensive assessment will be made of the resident's needs, strengths, goals, life history and preferences, using RAI (Resident Assessment Instrument) and will include at least the following: - Discharge planning Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment, as well as the date the data was obtained. The facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system (QUIES ASAP). Transmission of the MDS data will include the following documents in addition to those mentioned above; resident's transfer, entry, reentry, discharge, and death.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45830 Based on observation, interview and record review, the facility failed to ensure all residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and person hygiene for 4 of 8 (Resident #4, Resident #8, Resident #70 and Resident #83) residents reviewed for ADLs. The facility failed to ensure Resident #70's fingernails were trimmed. The facility failed to ensure Resident #8's fingernails were trimmed and cleaned. The facility failed to ensure Resident #83's toenails were trimmed. The facility failed to ensure Resident #4 received a facial shave. Findings included: 1. A record review of Resident #70's face sheet dated 2/29/2024 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of progressive supranuclear ophthalmoplegia (neurodegenerative disorder), muscle wasting and atrophy (muscle loss), need for assistance with personal care and psychotic disorder with delusions due to known physiological condition (hallucinations or delusions caused by another medical disorder). A record review of Resident #70's quarterly MDS assessment dated [DATE] reflected a BIMS score of 13, which indicated minimally impaired cognition. Section GG (Functional Abilities and Goals) reflected Resident #70 required supervision or touching assistance with person hygiene. A record review of Resident #70's care plan last revised on 1/30/2024 reflected she had ADL self-care performance deficit and required supervision and a one-person assist with personal hygiene. A record review of Resident #70's POC Response History for nail care dated 2/29/2024 reflected a lookback period of 30 days with No Data Found. A record review of Resident #70's POC Response History for bathing dated 2/29/2024 reflected her last shower or bath was given by CNA I on 2/28/2024. A record review of Resident #70's progress notes dated 12/30/2023-2/29/2024 reflected no documented refusals of nail care. During an observation and interview on 2/27/2024 at 11:22 a.m., Resident #70 was observed in her room with fingernails that extended approximately 0.5 cm from her fingertips. Resident #70 stated yes she liked her fingernails to be shorter and yes she would like them trimmed. Resident #70 stated she could not remember the last time her nails were trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/28/2024 at 9:01 a.m. revealed Resident #70 was ambulating in the secure unit and asked can I get my nails done while holding her hands up and displaying her nails. Observed Resident #70's fingernails to be the same length as before (extending approximately 0.5 cm from her fingertips) and Resident #70 said, they're too long. Observed LVN E tell Resident #70 that her nails would be done during her shower on the afternoon shift that day (2/28/2024). During an interview on 2/29/2024 at 10:18 a.m., the AAS stated she had done a nail activity the day prior (2/28/2024) in the secure unit but she had not trimmed any residents' nails, she just painted them. The AAS stated she had painted Resident #70's fingernails and I know [Resident #70] wanted her nails trimmed. The AAS stated she told Resident #70 a nurse needed to trim her nails and so she just painted them. The AAS stated she had not worked with male residents during the nail activity. 2. A record review of Resident #8's face sheet dated 2/29/2024 reflected an [AGE] year-old male readmitted on [DATE] with diagnoses of type 2 diabetes (uncontrolled blood sugar), hypertension (high blood pressure), memory deficit following cerebral infarction (stroke), chronic kidney disease and major depressive disorder (depression). A record review of Resident #8's quarterly MDS assessment dated [DATE] reflected a BIMS score of 4, which indicated severely impaired cognition. Section GG (Functional Abilities and Goals) reflected Resident #8 required partial/moderate assistance with personal hygiene. A record review of Resident #8's care plan last revised on 1/25/2024 reflected he had ADL self-care performance deficit related to dementia and required a one-person assist with person hygiene. A record review of Resident #8's POC Response History for nail care dated 2/29/2024 reflected a lookback period of 30 days with No Data Found. A record review of Resident #8's POC Response History for bathing dated 2/29/2024 reflected his last shower or bath was given by CNA I on 2/27/2024. A record review of Resident #8's progress notes dated 12/30/2023-2/29/2024 reflected no documented refusals of nail care. During an observation and interview on 2/27/2024 at 3:01 p.m., Resident #8 was observed sitting in his wheelchair in his room. Resident #8's fingernails were observed to have approximately 0.25 cm of the whites showing and there was a dark unidentifiable substance underneath them. Resident #8 stated, yes ma'am, I guess so when asked if his nails needed to be cleaned. An observation on 2/28/2/024 at 9:15 a.m. revealed Resident #8 was in his room and his fingernails were observed to be the same length as they were the day prior (approximately 0.25 cm for the whites of his nails) and with the same dark unidentifiable substance underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/29/2024 at 8:37 a.m., CNA M stated, when we see them long enough, we cut them and no there was no regular schedule for nail care. CNA M stated she had worked with Resident #70 and Resident #8 that day and most of them got their nails the day prior (2/28/2024) during the nail activity. CNA M stated she was not sure whether residents had their nails trimmed during the activity or just painted. CNA M observed Resident #70's fingernails and said they appeared long. Observed Resident #70 tell CNA M you can cut them and Resident #70 stated her fingernails were too long. During an observation and interview on 2/29/2024 at 8:41 a.m., CNA M stated Resident #8's and Resident #70's shower days were on Wednesday evenings, and she was not sure whether they received a shower (on 2/28/2024) because she worked day shift. Observed CNA M look at Resident #8's fingernails and she said they needed to be cut and were dirty. 3. A record review of Resident #83's face sheet dated 2/29/2024 reflected an [AGE] year-old female readmitted on [DATE] with diagnoses of unspecified dementia, age-related physical debility, muscle wasting and atrophy (muscle loss) and need for assistance with personal care. A record review of Resident #83's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, which indicated severely impaired cognition. Section GG (Functional Abilities and Goals) reflected Resident #83 required substantial/maximal assistance with personal hygiene. A record review of Resident #83's care plan last revised on 1/09/2024 reflected she had ADL self-care performance deficit related to humeral fracture (broken leg) and history of unsteady gait. A record review of Resident #83's POC Response History for nail care dated 2/29/2024 reflected a lookback period of 30 days with No Data Found. A record review of Resident #83's POC Response History for bathing dated 2/29/2024 reflected his last shower or bath was given by CNA L on 2/29/2024. A record review of Resident #83's progress notes dated 12/30/2023-2-29/2024 reflected no documented refusals of nail care. An observation on 2/27/2024 at 3:19 p.m. revealed Resident #83 was lying in her bed. Resident #83's toenails appeared thick, long (approximately 1 cm from tip of toes), curved and jagged. Resident #83 was non-interviewable and did not speak. CNA L was present inside Resident #83's room and stated Resident #83 had one toenail on the right foot that looked long to her and all the toenails on the left foot looked long to her. CNA L stated she did not trim Resident #83's toenails because she refused. CNA L stated she had notified Resident #83's hospice nurse but did not say whether she had notified the facility nurse. CNA L stated she did not touch residents' toes who were diabetic but said no Resident #83 was not diabetic. CNA L stated I couldn't tell you when asked if hospice provided nail care. During an observation and interview on 2/29/2024 at 9:03 a.m., Resident #83 was observed in her room. Resident #83's toenails were observed to be the same length as the day prior (extending approximately 1 cm from the tip of her toes) and appeared curved, jagged, and thick. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A record review of Resident #4's face sheet dated 2/29/2024 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of unspecified dementia, muscle wasting and atrophy (muscle loss), age-related debility, hypertension (high blood pressure) and need for assistance with personal care. A record review of Resident #4's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, which indicated severely impaired cognition. Section GG (Functional Abilities and Goals) reflected Resident #4 required partial/moderate assistance with personal hygiene. A record review of Resident #4's care plan last revised on 1/14/2024 reflected she had ADL self-care performance deficit related to muscle weakness. A record review of Resident #4's POC Response History for bathing dated 2/29/2024 reflected her last shower or bath was given by CNA L on 2/29/2024. A record review of Resident #4's progress notes dated 12/30/2023-2/29/2024 reflected no documented refusals of care documented. An observation on 2/27/2024 at 3:23 p.m. revealed Resident #4 was ambulating in the secure unit, and she had facial hair on her chin which was approximately 0.75 cm long. Resident #4 was non-interviewable and did not speak. During an interview on 2/28/2024 at 8:20 a.m., Resident #4's family member stated he visited every two weeks. Resident #4's family member stated he had just visited a few days prior and told Resident #4 'you have a better beard than I do'. Resident #4's family member stated when she took care of herself at home, she was very much aware of facial hair and would tweeze hairs poking out when she saw them. Resident #4's family member stated I'm sure she would appreciate if staff trimmed her facial hair. During an observation and interview on 2/29/2024 at 8:57 a.m., CNA L stated nail care was done on Sundays or on shower days by CNAs. CNA L stated shaving was done on shower days by CNAs or if staff noticed it needed done, they would go ahead and do it. CNA L stated she had given a shower to Resident #4 on Tuesday 2/27/2024 and no she did not notice any facial hair on Resident #4. CNA L looked at Resident #4 closely and said she had two little whiskers that she estimated were approximately 0.5 cm long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/29/2024 at 2:17 p.m., the DON stated CNAs were responsible for providing nail care and shaving care on shower days, if they see fit or if residents requested. The ODN stated if residents or family requested shaving care for female residents, the facility could do it. The DON stated, we could ask family if they didn't mind us doing that. The DON stated she had never ran across that situation. The DON stated she had not noticed facial hair on Resident #4. The DON stated she was not aware of whether any staff had consulted Resident #4's family about trimming her facial hair. The DON stated residents were monitored to ensure they received nail care, shaving and grooming by nurses, CNAs and families. The DON stated CNAs were monitored via nurses by looking at and signing off on shower sheets. The DON stated she had not seen Resident #70's or Resident #8's fingernails that week but said Resident #70 got her nails done during activities and she doesn't let you do her nails. The DON stated she had not seen Resident #83's toenails but said if they were long and curved, she expected podiatry to take care of them. When asked if staff could trim Resident #83's toenails or if she required podiatry, the DON stated she would have to look at Resident #83's toenails. The DON stated staff were trained on providing nail care and grooming to residents with dementia through skills fairs, in-services and computer-based trainings. The DON stated if residents did not receive nail care, it could cause infection. The DON stated she did not know what affect there could be if female residents had unwanted facial hair. During an interview on 2/29/2024 at 4:00 p.m., the Administrator stated she expected residents to be offered care if it were something that needed done. The Administrator stated Resident #4 did not like to be shaved but yes it was a possibility her dementia played a role. The Administrator stated she expected staff to offer three times before accepting a refusal. The Administrator stated nails should be clipped and cleaned by CNAs every time the resident had a shower. The Administrator stated CNAs were monitored by nurses and by the DON to ensure nail care and grooming was provided. The Administrator stated nurses monitored through shower sheets and by putting eyes on them. The Administrator stated staff were trained on providing nail care and shaving care to residents with dementia through computer-based trainings and yes they had all been trained. The Administrator stated if residents did no receive nail care or shaving care, it could be an infection control concern, a resident rights issues, and a dignity concern. A record review of the facility's computer-based training report dated 2/29/2024 for Alzheimer's disease-related modules reflected CNA L and CNA I had completed the coursework, but LVN E and CNA M had not. A record review of the facility's undated policy titled Nursing Services - ADLs reflected the following: POLICY: Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each residents' quality of life and promotes care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality. Each resident . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER Onion Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Onion Creek Pkwy Austin, TX 78748	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Receives or is provided the necessary care and services enabling rum/her to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehension assessment and plan of care. o Residents receive assistance as needed to manage their physical needs which includes personal hygiene grooming, dressing, toileting, transferring, ambulating and eating. o Resident or his/her representative has the right to refuse care and treatment. Refusal of care will be documented in the clinical record with a plan to minimize or decrease functional loss. Residents may refuse or resist care due to dementia. Attempts will be made to identify cause for refusal and alternate ways to provide care as appropriate.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on observation, interview and record review, the facility failed to ensure all residents were provided, based on the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities, designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident for 1 of 8 (Resident #89) residents reviewed for activities. The facility failed to provide regular, individualized activities to Resident #89. This failure placed residents at risk of decreased physical, mental, and psychosocial well-being. Findings included: A record review of Resident #89's face sheet dated 2/29/2024 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of dementia with agitation and behavioral disturbance, muscle wasting and atrophy (muscle loss), lack of coordination, and adjustment disorder with mixed anxiety and depressed mood (maladaptive response to a psychosocial stressor). A record review of Resident #89's quarterly MDS assessment dated [DATE] reflected he was unable to be assessed for a BIMS (cognition test) score due to rarely/never being understood. A review of Section D (Mood) reflected that in a lookback period of two weeks, Resident #89 exhibited the following symptoms between two to six days: had little interest or pleasure in doing things, felt or appeared down, depressed or hopeless, had trouble falling asleep, staying asleep or slept too much, and felt tired or had little energy. A record review of Resident #89's care plan last revised on 1/25/2024 reflected he had potential for psychosocial well-being problem related to anxiety. Goals for this problem reflected will identify appropriate diversional activities by the review date, will identify individual strengths by the review date and will demonstrate adjustment to nursing home placement by/through review date. Interventions reflected encourage participation from resident who depends on others to make own decisions. Resident #89's care plan reflected he had little or no activity involvement related to him not wanting to participate. Resident #89's goal for this focus area reflected will express satisfaction with type of activities and level of activity involvement when asked through the review date. Interventions reflected activities and nursing staff were to provide an activities calendar, invite Resident #89 to scheduled activities and explain to him he may leave at any time. A record review of Resident #89's Quarterly Activity Evaluation authored by the AS dated 2/02/2024 reflected the following: Resident really enjoys physical activities like balloon tennis, kickball, cornhole. Resident needs a lot of encouragement from staff to attend activities. Resident sleeps often and is sometimes hard to motivate to get up for activities. He can be bribed with chocolate to attend (his daughter/nurse are ok with it). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #89's progress notes dated 12/20/2023-2/29/2024 reflected no documentation of activity participation, encouragement to attend, or refusals of activities. A record review of Resident #89's progress note dated 1/16/2024 reflected Chief Complaint/ Nature of Presenting Problem: Depression and History Of Present Illness: Patient seen in bed and not a great historian. He did deny any acute confusion being tired depression or being angry. Psychiatry notes reviewed. Remeron and trazodone were added for insomnia. And they noted stable adjustment disorder. However when discussing with nursing today they state he has had intermittent worse p.o. intake and noticed that his depression symptoms have been increased for the last 1 week or more. A record review of Resident #89's progress notes dated 2/01/2024 reflected He does endorse depression and psych services is on board. His appetite has declined. Discussing with nurse they are thinking of moving him out of memory care unit I assume to help with depressive state. During an observation and interview on 2/27/2024 at 9:54 a.m., Resident #89 was observed lying in bed. Resident #89 did not voice any concerns. During an interview on 2/29/2024 at 2:07 p.m., Resident #89's family member stated she used to visit every Sunday but started visiting once every two to three weeks. Resident #89's family member stated the facility expressed concern over Resident #89 being depressed since he moved to the 300 halls but said Resident #89 had always been on the 300 hall. Resident #89's family member stated he's just kind of there when asked if she believed he was depressed. Resident #89's family member stated Resident #89 was hard to motivate but said Resident #89 used to be a mechanic and liked being out and back. Resident #89's family member explained that Resident #89 enjoyed leaving the facility from time to time. Resident #89's family member stated the facility reported they had attempted to engage Resident #89 in activities but did not say what type of activities. Resident #89's family member stated the secure unit had a porch but she had never seen anyone out there. Resident #89's family member stated Resident #89 liked to tinker with things, enjoyed talking about fixing brakes, and getting outside and walking. Resident #89's family member stated she attended Resident #89's care plan meeting approximately one week ago, the AS was there, and they discussed activities that Resident #89 would enjoy. An observation on 2/28/24 at 9:05 a.m. revealed Resident #89 was sleeping in bed and an activity calendar was posted on the wall in his room. During an interview on 2/29/2024 at 9:15 a.m., the AS stated she had worked as the activity director for one year, was familiar with Resident #89, and said he was lacking motivation at that time. The AS reported Resident #89 enjoyed physical activities but said it was hard to get him out of bed. The AS said Resident #89 enjoyed cornhole, darts, balloon volleyball, anything outside, and sweets. When asked how many physical activities the facility had, the AS stated therapy worked with him a lot and they try to do one physical activity per day. The AS stated she was trying to figure out Resident #89's background and she got most of her information from family. When asked if there were any changes to Resident #89's care plan following the meeting with family, the AS stated, he's doing better with activities and therapy so no. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 2/29/2024 at 9:37 a.m. revealed a bingo activity was occurring in the dining room in the secure unit but Resident #89 was in bed sleeping. During an interview on 2/29/2024 at 9:42 a.m., LVN F reported the activity included snacks such as sandwiches and cookies. During an interview on 2/29/2024 at 10:05 a.m., the AAS stated she herself and the AS formulated the activity calendar every month and Resident #89 was most responsive to balloon volley ball. The AAS stated it seemed as though Resident #89 had declined a bit in the last few months. The AAS stated herself and the AS did one-on-one activities with Resident #89 and those were documented in their activity binder. The AAS stated Resident #89 received a one-on-one activity once per week. The AAS stated I'm not sure if staff were motivating Resident #89 to get up for activities and said personally, she had not seen staff encouraging him to get out of bed. During an interview on 2/29/2024 at 4:11 p.m., OTA O stated she worked with Resident #89 twice a week for OT and he received PT three times a week. OTA O stated Resident #89 had been self-limiting lately and lately it's been anything to get him to leave the bed. OTA O stated she had not witnessed any one-on-one activities with Resident #89 but said she was not in his room all day. During an interview on 2/29/2024 at 2:07 p.m., the DON stated the AS and the AAS provided activities to residents. The DON stated Resident #89 was still bouncing back from having pneumonia. The DON stated, it depends on the person whether six one-on-one activities in a three-month period was sufficient to meet Resident #89's needs. The DON stated participating in activities could be good for someone but for someone else they might not care and stated it was a preference. The DON stated she had never seen Resident #89 participate in group activities and we offer one-on-one activities to resident who did not participate in group activities. The DON stated therapy staff provided activities to Resident #89 as well. The DON stated she did not know what had been offered and she expected activities staff to document activities in Resident #89's chart. The DON stated it depended on the resident as far as what negative outcome could occur with lack of activities and said she did not know whether it would or would not affect Resident #89. During an interview on 2/29/2024 at 4:00 p.m., the Administrator stated the AAS, the AS, and therapy provided activities to residents. The Administrator. The Administrator stated she thought Resident #89 enjoyed exercises and being by himself. The Administrator stated she thought Resident #89 did one-on-one activities when asked how he had his activities needs met. When asked how often Resident #89 was offered activities he enjoyed, the DON stated, I would think daily. The Administrator stated It depends on the person whether six one-on-one activities were sufficient to meet Resident #89's needs. The Administrator stated, possibly that Resident #89 might participate in activities more often if he were offered activities that he enjoyed. The Administrator stated if resident were not provided activities to meet their needs, it could result in decreased quality of life and depression A record review of Resident #89's Record of One-on-One Activities reflected he had received one-on-one activities on 11/15/2023, 12/04/2023, 1/16/2-24, 2/02/2024, 2/12/2024, and 2/23/2024. A record review of the facility's policy titled Activities Program dated July 2017 reflected the following: POLICY: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to ensure each resident has daily social, recreational, or rehabilitative activities provided and available to them. PROCEDURES: 1. Activities are planned according to the residents' preferences, needs, and abilities. Every resident will be interviewed for preferences. 2. A calendar of activities is: a. Prepared at least one week in advance from the date the activity will be provided b. Conspicuously posted c. Reflects all substitutions in the activities provided d. Maintained on the premises for 12 months after the last scheduled activity 3. Equipment and supplies are available and accessible to accommodate each resident who chooses to participate in an activity. 4. Daily newspapers, current magazines, and a variety of reading materials are available and accessible to all residents in facility A record review of the facility's undated policy titled Nursing Services - ADLs reflected the following: POLICY: Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each residents' quality of life and promotes care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality. Each resident . Chooses activities, schedules, and health care consistent with his or her interest, assessments and plans of care and makes choices about aspects of his or her life in the facility that are significant to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident or his/her representative has the right to refuse care and treatment. Refusal of care will be documented in the clinical record with a plan to minimize or decrease functional loss. Residents may refuse or resist care due to dementia. Attempts will be made to identify cause for refusal and alternate ways to provide care as appropriate.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview and record review, the facility failed to provide the physician prescribed therapeutic diet to 1 of 4 residents (Resident #298) reviewed for therapeutic diets, in that: Resident #2 did not receive no salt added diet as ordered. This failure affected one resident and placed her at risk for using the salt and causing further health issues. Findings included: Resident #298 Record review of Resident #298's face-sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Atrial fibrillation, Severe Protein-Calorie Malnutrition, Chronic Diastolic (Congestive) heart Failure, Morbid obesity due to excessive calories, Long term(current) use of anticoagulants, Generalized Edema, Reflux disease, High Blood Pressure, Dysphagia Oral Phase Record review of Resident #298's Dietary Orders revealed Resident 298 is on a regular diet: regular texture, Thin Liquids consistency NO added salt. Interview with Resident 298's POA on 02/27/2024 at 2:58pm revealed resident has history of heart problems and was put on a heart healthy diet. POA revealed that when Resident 298 was sent back to the nursing facility they have been giving her regular diet with the salt. Interview with LVN C on 02/27/2029 at 3:39pm revealed that he was not sure if Resident 298 was on a regular diet or not. He stated he could look and see in the system to see what diet is ordered. He stated that when there was a change to a diet a new slip was given to the dietary supervisor so he can change the diet. Observation of Resident 298's food tray and meal ticket on 02/28/2024 at 12:54pm revealed the ticket did not say no salt and there was a salt packet on the tray. Observation of Resident 298's breakfast tray on 02/29/2024 at 8:12am revealed she had salt on the tray. The meal ticket did not reflect no salt. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN D on 02/29/2024 at 10:03am revealed the meal trays are check by the nurse aids and the nurses. She stated when there was a new resident a yellow dietary slip will be filled out according to the resident's orders and given to the dietary supervisor. LVN D stated if there was a change in dietary orders then the nurse practitioner will write the new order. She revealed that they check for pending orders at least twice a day because the system does not send them a notification that a new order was pending. She stated after they get the new order, they will print the order out and give to the Dietary Supervisor. LVN D stated she was not sure how the dietary order for Resident 298 was not correct. She stated the risk of the resident not getting the proper diet could cause the resident to choke, or aspirate. Interview with Dietary Supervisor on 02/29/2024 at 10:15am revealed that he would know when they are getting a new resident but does not know their diet until they bring him the yellow diet slip. He stated he would get the dietary slip within an hour of the resident's arrival. When asked about Resident 298's diet card he stated that she was on a regular diet. He stated that admissions give him the diet order he does not see the actual order. Interview with the DON on 02/29/2024 at 11:45am revealed that when there was a new resident or change the nurse petitioner does the dietary order. She stated they put on a communication slip (the yellow diet slip) and give it to the dietary supervisor. She stated there was a report that was pulled daily and if it says heart healthy it would be changed to no salt added and low sodium on the dietary slip. She stated they do not leave it as heart healthy because most do not understand what a heart healthy diet was so the language was changed to simple terms. Record Review of the dietary slip given to the Dietary Supervisor on 2/12/2024 revealed Resident #298 was a new admission. The dietary slip just stated that the resident was to have house shake at lunch and dinner. The slip did not address the no salt added diet. Record Review of Resident 298's meal ticket on her tray revealed she is on a regular diet. The ticket did not say no salt added. Record review of Resident 298's dietary orders dated 02/11/2024 revealed Resident 298 was on a regular texture thin liquid consistency, no salt added. Record Review of Dietary Services: Meals and Foods Policy dated 06/17 revealed therapeutic diets as ordered by the resident's physician are provided according to the service plan.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for foods safety for 1 of 1 kitchen reviewed for food safety and sanitation. The facility failed to ensure all food items were labeled and dated. The facility failed to ensure dishes were sanitized at the correct concentration of sanitizer (50 ppm). The facility failed to ensure employee's personal food items were stored separately from resident food items. These failures placed residents at risk of foodborne illness. Findings included: An observation of the walk-in refrigerator on [DATE] at 9:14 a.m. revealed two packages of ground unidentifiable without a label or date. Both items were covered with a layer of frost. An observation of the walk-in refrigerator on [DATE] at 9:16 a.m. revealed a plastic storage container labeled ham and cheese dated [DATE] but the contents were five individually wrapped unidentifiable substances. An observation of the walk-in refrigerator on [DATE] at 9:20 a.m. revealed two plastic sacks of unlabeled and undated food items. During an interview on [DATE] at 9:20 a.m., CK K stated the two plastic sacks were employee lunches and they did not have a refrigerator for employee food items. During an observation and interview on [DATE] at 9:25 a.m. revealed DA N was washing dishes using the dish machine in the dish room. Observed DA N measure the sanitizer and it read 25 ppm. The Dietary Supervisor stated the dish machine had just been serviced last week but he would call again. The Dietary Supervisor stated the test strips were new and said the sanitizer appeared to be measuring 25 ppm. An observation on [DATE] at 9:30 a.m. revealed CK K measured the dish machine's sanitizer again and it was still 25 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 10:00 a.m., the Dietary Supervisor stated the technician would be arriving at the facility to look at the dish machine. Observed the Dietary Supervisor test the concentration of the sanitizer water and it again read 25 ppm. Observed staff were still using the dish machine to wash and sanitize dishes. The Dietary Supervisor stated it was his understanding that the concentration of the sanitizer needed to be between ,d+[DATE] ppm. The Dietary Supervisor stated it's not 50 but said the sanitizer was measuring between ,d+[DATE] ppm. The Dietary Supervisor stated he had called a technician and the technician would be at the facility in an hour. During observations of the process for pureeing food items on [DATE] from 10:02 a.m.-10:14 a.m., CK K was observed pureeing carrots and black beans. CK K pureed carrots, DA N washed the food processor using the dish machine, and CK K used the food processor to then puree black beans. The three-compartment sink was observed to be empty and was not in use. During an interview on [DATE] at 10:18 a.m., the Dietary Supervisor stated the facility did not have policies for the kitchen, but said they followed the TFER. The Dietary Supervisor stated yes the facility followed the FDA Food Code as well. During an observation and interview on [DATE] at 10:22 a.m., the Dietary Supervisor stated the dish machine was a low temperature dish machine and the sanitizer needed to be between ,d+[DATE] ppm. The Dietary Supervisor stated there was a break room where staff needed to store their personal lunches. The Dietary Supervisor stated he had a discussion with dietary staff before on where to keep their lunches. The Dietary Supervisor stated usually staff stored their lunches in the walk-in cooler but said no storing them in the walk-in was not okay either. The Dietary Supervisor stated the five bags of unidentifiable substance which were in a container labeled ham and cheese were actually vegetarian soy patties. The Dietary Manager stated he did not know why it was labeled incorrectly. The Dietary Supervisor stated the two logs of unidentifiable ground meat were ground beef, and he said he told staff earlier that morning ([DATE]) they needed to put a date on it. During an observation and interview on [DATE] at 8:47 a.m., the Dietary Supervisor stated the technician had come the day prior ([DATE]) and fixed the dish machine. The Dietary Manager stated the pipe had been clogged and he did not know whether it was the one the sanitizer flowed through. Observed the ppm was then measuring 50 ppm. The Dietary Supervisor stated staff should be checking the dish machine concentration after every meal and he had done verbal training with staff on reading the chemical concentration and temperature-he stated the last time staff were trained in that area was two weeks prior. The Dietary Supervisor stated he himself had been trained over time and through speaking with the sales representative. The Dietary Supervisor stated the guy told him it was safer to keep the dish machine at 50 ppm. Observed a placard on the dish machine which reflected the concentration of chemicals needed to be at 50 ppm and the minimum temperature needed to be 120 F. The Dietary Supervisor stated he had never noticed that placard before and then said the sanitizer should be 50 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:18 p.m., the RDN stated she had been visiting the facility since July of 2023. The RND stated yes items should be labeled with what they were, and meats pulled from the freezer should be dated with a pull date. The RDN stated she had trained dietary staff on using the dish machine and yes she expected the Dietary Supervisor to ensure the chemicals were maintained at 50 ppm. The RDN stated if the sanitizer was not reaching 50 ppm, she expected dietary staff to stop using the dish machine, get maintenance and try to find out what was wrong with it. The RDN stated if the dish machine were not functioning, staff should sanitize dishes via the three-compartment sink or use paper products for serving. The RDN stated she was unsure how the Dietary Supervisor trained new staff, but they should shadow someone for a few days before being on their own. The RDN stated if she saw staff doing something wrong, she would provide demonstrative training. The RDN stated yes she had noticed some issues with the dish machine not running at the proper ppm and said maintenance had looked at it a couple times. The RDN stated she had first identified issues with the dish machine in August of September of 2023. The RDN stated the previous dietary manager would check the dish machine himself every day after the issues had been identified but said she was not sure whether the Dietary Supervisor was checking it himself daily. The RDN stated the Dietary Supervisor was fairly new. The RDN stated she had brought up the issue with the dish machine to the DON, Administrator and Dietary Supervisor by documenting the issue in her monthly sanitation audit, which was emailed out to the facility. The RND stated if food were not stored properly or if the dish machine were not functioning like it should, it could lead to bacteria and residents could get sick. During an interview on [DATE] at 10:00 a.m., the Dietary Supervisor stated he did not check the dish machine every day, but he ensured dietary staff checked it. During an interview on [DATE] at 3:51 p.m., the Administrator stated she expected food items to be labeled and dated properly and yes containers should be accurately labeled with what they contained. The Administrator stated she expected the Dietary Supervisor to be able to follow protocol and follow standards for the dish machine. The Administrator stated she expected staff to use paper products if the dish machine were not functioning properly. The Administrator stated dietary staff were trained on food storage and sanitization via computer-based training. The Administrator stated the RDN, Dietary Supervisor a dietary resource person monitored the kitchen for food safety. The Administrators stated if foods were no stored properly or if the dish machine were not functioning, resident could be at risk for having expired food, spoiled food, and yes foodborne illness. A record review of the facility's monthly kitchen sanitation audit dated [DATE] authored by the RDN reflected no to the following sanitation items: -Personal beverages: lid on and not in food prep area -3 Compartment sink: used appropriately, ppm and temp correct A record review of the facility's monthly kitchen sanitation audit dated [DATE] authored by the RDN reflected items in the refrigerator did not have open dates. There were no notes indicating the dish machine was not functioning properly. A record review of the facility's monthly kitchen sanitation audit dated [DATE] authored by the RDN reflected items in the refrigerator were without open dates and the dish machine log was incomplete. There were no notes indicating the dish machine was not functioning properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER Onion Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Onion Creek Pkwy Austin, TX 78748	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the facility's monthly kitchen sanitation audit dated [DATE] authored by the RDN reflected items in the refrigerator were without opened dates. There were no notes indicating the dish machine was not functioning properly. A record review of the facility's monthly kitchen sanitation audit dated [DATE] authored by the RDN reflected employee personal beverages were in the food prep area and the dish machine log was incomplete. There were no notes indicating the dish machine was not functioning properly. A record review of the facility's policy titled Dietary Services dated [DATE] reflected the following: POLICY: It is the policy of this facility to ensure dietary services are provided to our residents operating within the confines of Texas state regulations. 1. A dietary manager is responsible for the total food service of this facility 8. Food purchased, stored, and served in this facility is labeled and dated according to all applicable food service regulations 9. Food prepared for consumption by our residents is prepared according to all applicable food service regulations. A record review of the FDA's 2022 Food Code reflected the following: ,d+[DATE].113 Warewashing Machine, Data Plate Operating Specifications. The data plate provides the operator with the fundamental information needed to ensure that the machine is effectively washing, rinsing, and sanitizing equipment and utensils. The warewashing machine has been tested , and the information on the data plate represents the parameters that ensure effective operation and sanitization and that need to be monitored. ,d+[DATE].11 Food Contact with Equipment and Utensils. Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized. They may also be passed on by consumers or employees directly, or indirectly from used tableware or food containers. Some pathogenic microorganisms survive outside the body for considerable periods of time. Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination. ,d+[DATE].14 Sanitizing Solutions, Testing Devices. Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization; and 2. Too much sanitizer in the final rinse water could be toxic. ,d+[DATE].15 Warewashing Machines, Manufacturers' Operating Instructions. To ensure properly cleaned and sanitized equipment and utensils, warewashing machines must be operated properly. The manufacturer affixes a data plate to the machine providing vital, detailed instructions about the proper operation of the machine including wash, rinse, and sanitizing cycle times and temperatures which must be achieved. ,d+[DATE].11 Storage. Employee personal care items may serve as a source of contamination and may contaminate food, food equipment, and food-contact surfaces if they are not properly labeled and stored. ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.