STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676291	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakcrest Nursing and Rehabilitation Center	9808 Crofford LN Austin, TX 78724

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for 1 of 8 (Resident #2) residents reviewed for resident rights.1. The facility failed to ensure that Resident #2's room was free from standing urine and bugs on 3/11/2026.2. The facility failed to ensure that Resident #2's curtain was clean and free of stains on 3/11/2026.3. The facility failed to ensure the flooring was not damaged in the east hallway on 3/11/2026.These failures placed residents at risk for an unclean, unsafe, and uncomfortable environment.Findings included:A record review of Resident #2's face sheet dated 3/11/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (neurocognitive disease), bipolar disorder (manic depression), other schizophrenia (psychosis), cerebral infarction (stroke), type 2 diabetes (uncontrolled blood sugar), major depressive disorder (depression), Alzheimer's disease (neurocognitive disease), and dysphagia (difficulty swallowing).A record review of Resident #2's MDS assessment dated [DATE] reflected no BIMS score. Resident #2 required setup or clean-up assistance with personal hygiene.A record review of Resident #2's care plan last revised on 12/02/2025 reflected that he was at risk for increased confusion and decline in ADLs as his disease progressed.During an interview on 3/11/2026 at 10:46 AM, HK A stated that the process for cleaning resident rooms included cleaning windows, lights, taking out trash, sweeping, mopping, and disinfecting everything.An observation on 3/11/2026 at 10:58 AM revealed the laminate floor paneling in the east hallway was peeled off and raised.During an interview on 3/11/2026 at 12:00 PM, Resident #1 stated that another resident peeled off the floor.During an observation and an attempted interview on 3/11/2026 at 12:25 PM, Resident #2 was observed sitting in his wheelchair in his room. Resident #2 did not answer any questions and was non-interviewable. There was a urinal on a table in front of him about one third full of dark, yellow urine. Behind the urinal was an upside-down foam cup. There were 25 small bugs visible on and around the urinal and the foam cup. The urinal appeared to be stained and the plastic appeared to be corroded.During an observation and interview on 3/11/2026 at 12:27 PM, CNA B stated that the last time he went into Resident #2's room was around 9:00 AM that day (3/11/2026). CNA B stated that Resident #2 liked to empty his own urinal, and sometimes he refused to have it emptied, but that morning (3/11/2026) he did not refused. Observed CNA B enter Resident #2's room, grab the urinal, and walk towards the door. CNA B stated that the toilet in Resident #2's room was not working, so he had to empty it somewhere else. Resident #2's curtains were stained with a brown substance. CNA B stated that the Maintenance Director was responsible for taking down resident curtains so housekeeping could wash them. CNA B stated that Resident #2's curtains were nasty. CNA B stated there were a lot of bugs around the urinal and he did not know what kind of bugs they were.During an interview on 3/11/2026 at 1:37 PM, the Maintenance Director stated that nurses would notify them of any pest control issues and it was his responsibility to monitor for pests. The Maintenance Director stated he had not entered Resident #2's room that day (3/11/2026). After viewing a photo of Resident #2's urinal, the Maintenance Director stated that the bugs were gnats. The Maintenance Director stated that based on the number of gnats in the picture of (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's urinal, he would guess that the urine must have sat there for two days. The Maintenance Director stated that the flooring in the east hallway that was peeled would be repaired next week, and to his knowledge, no residents had tripped over the peeled floor. The Maintenance Director stated that staff were supposed to notify him or housekeeping when residents' curtains needed to be removed for cleaning. The Maintenance Director stated that Resident #2's curtains looked dirty and should have been changed.During an interview on 3/11/2026 at 2:04 PM, the DON stated that the facility was sprayed for pests every two weeks and it was everybody's responsibility to monitor resident rooms for pests. The DON stated that he rounded randomly in resident rooms, but had not been in Resident #2's room that morning (3/11/2026). The DON stated that because it rained hard that morning (3/11/2026), the standing water outside from the rainfall the night prior (3/10/2026) could have attracted gnats to Resident #2's urinal. The DON stated he did not know how residents could be effected by pests.During an interview on 3/12/2026 at 11:34 AM, the Administrator stated the facility had policies with maintenance to repair things, policies for housekeeping for cleanliness and a resident rights policy for homelike environment. The Administrator stated that the Maintenance Director was over housekeeping and laundry; he was the one who in-serviced housekeeping staff. The Administrator stated it was everyone's job to monitor for things that needed repair, and that everyone was responsible for maintaining a homelike environment. The Administrator stated that CNAs and housekeepers needed to report environmental concerns. The Administrator stated that the DON in-serviced CNAs, and he believed they had all been trained on things that needed to be reported. The Administrator stated that staff made him aware of Resident #2's curtain and it was replaced. The Administrator stated he believed the Maintenance Director had a schedule for replacing curtains. The Administrator stated that he assumed urinals were emptied once a day. The Administrator stated that pest control happened monthly, and he would have to check when they last came. The Administrator stated the floor was superficial and the problem was that they did not make the same type of board but remodeling was in the works and it was a big project that they had phases for. The Administrator stated that staff made him aware of Resident #2's urinal. The Administrator stated that there had not been any complaints about the environment and that it was not a health issue. The Administrator stated, potential is there, but it hasn't happened. The Administrator stated that the curtains and urinal were addressed. The Administrator stated, we have systems in place to address it. The Administrator stated that potential was vague and that everything had potential.A record review of the facility's undated policy titled Internal Environmental Services reflected the following: Purpose:-Assure that the residence remains a pleasant place to live.Procedure: The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventive maintenance program, and repair or enhancement of existing structures, systems, and fixtures.A record review of the facility's undated policy titled RESIDENT'S RIGHTS UNDER TEXAS LAW reflected the following: You have a right:.2) to safe, decent and clean conditions;

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident for 1 of 8 (Resident #1) residents reviewed for comprehensive care plans.The facility failed to include Resident #1's history of trauma, history of delusions, and diagnoses of schizophrenia and bipolar disorder were captured in her comprehensive care plan.This failure placed residents at risk of not receiving interventions to address their diagnoses and trauma.Findings included:A record review of Resident #1's face sheet dated 3/12/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cognitive communication deficit (difficulty communicating), restlessness and agitation, unspecified dementia (neurocognitive disorder), bipolar disorder (manic depression), and schizoaffective disorder (psychosis).A record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated intact cognition.A record review of Resident #1's care plan on 3/11/2026 reflected no mention of Resident #1's history of sexual trauma, delusional behavior, or diagnoses of schizophrenia and bipolar disorder.A record review of Resident #1's care plan on 3/12/2026 reflected that her care plan was revised on 3/11/2026 to include the following: that she was a victim of physical abuse and interventions included that staff were to provide a safe environment for the resident, establish safety and trust from the resident, discuss safe and healthy relationship skills, and provide referrals and resources. There were no interventions related to her delusional behavior or diagnoses of schizophrenia and bipolar disorder.A record review of Resident #1's clinical treatment plan review authored by the Psychologist dated 8/22/2023 reflected that she experienced rape and head injuries while living with others and on the street.A record review of Resident #1's progress note dated 3/11/2026 reflected that she had increased manic behavior and made a claim regarding an alleged rape occurrence.During an observation and interview on 3/11/2026 at 12:00 PM, Resident #1 was observed walking in the hallway. Resident #1 stated she felt safe in the facility and that staff treated her well.During an observation and interview on 3/11/2026 at 1:16 PM, Resident #1 was observed standing in the hallway. Resident #1 told the HHSC Surveyor that she wanted them to have a letter and then she handed the Surveyor a letter, which reflected the following: I'm being used and neglected in the system and to why one knows where abouts are [NAME] to me but when I was raped I had none.During an interview on 3/11/2026 at 1:55 PM, the DON stated, we do care plans as things happen and that his nurses and himself were responsible for revising care plans. The DON stated that he did the clinical side of care plans, but that he did not do a clinical background check.During an interview on 3/12/2026 at 11:34 AM, the Administrator stated that the DON was responsible for updating care plans. The Administrator stated that if a resident were a victim of sexual assault, it should be in the care plan if they were seeing psych. The Administrator stated he just found out about Resident #1's history of sexual assault when she wrote the letter (on 3/11/2026). The Administrator stated that the SW was already aware of that history, and he did not know why it had not been included in Resident #1's care plan until 3/11/2026. The Administrator stated that care plans fluctuated depending on what was going on. When asked how not having that history in Resident #1's care plan could affect her, the Administrator stated that nursing should know about Resident #1's history. When asked how residents could be affected by not having an updated care plan, the Administrator stated that there was potential for a negative outcome if those things were missed. During an interview on 3/12/2026 at 12:12 PM, the SW stated that she had worked in the facility for seven years and she was aware of Resident #1's history. The SW stated that Resident #1 was admitted before the SW started working in the facility and they may or may not have entered that into an initial social services note regarding Resident #1's history of assault. The SW stated that Resident #1's behavior of recalling her trauma came and went. The SW stated that the incident really shaped (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's life and how her life went. The SW stated that it drastically changed the dynamic in her family, and she wound up homeless and getting into drugs. The SW stated that Resident #1 saw a psychologist, but did not want to work on her problems or assistance with working through her memories so she was discharged . The SW stated that the DON was normally the one who updated care plans, and that she did not revise care plans. The SW stated that Resident #1's schizophrenia and delusions had always been present and that Resident #1 had not had periods in which she did not exhibit those behaviors.A record review of the facility's policy titled CARE PLANNING dated 12/13/2020 reflected the following: Policy; To ensure that a comprehensive person centered Care plan is developed for each resident based on their individual assessed needs.Procedure 1. The Facility will develop a person centered baseline Care Plan for each resident. The Care plan will include at least the following information:.d. Social services