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	07/17/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on interview and record review the facility failed to ensure all alleged violations involving neglect were reported immediately or within 2 hours if the alleged violation involved abuse or neglect resulted in bodily injury, to other officials for 1 of 5 residents (Resident #47) reviewed for abuse and neglect in that: The facility failed to report to the State agency when Resident #47 had an incident of choking on [DATE]. He was pronounced dead at the facility by EMS on [DATE] at 6:04 PM. This failure could place current residents on a mechanically altered diet at risk of having an incident go unreported and uninvestigated. Findings included: Record Review of Resident #47's face sheet dated [DATE] revealed Resident #47 was a [AGE] year-old male admitted on [DATE] with diagnoses Nausea with vomiting, depressive disorder, reflux, high level of fat particles in the blood, Urinary tract infection, brain disease, vitamin D deficiency, pre-diabetes, constipation, dementia, inflammatory disorder of the pancreas, sleeping disorder, Alzheimer's, lack of coordination, muscle weakness, and communication difficulty. Record review of Resident #47's quarterly MDS dated [DATE] revealed he was on a mechanical soft diet and was independent when eating. Record review of Dietary orders dated [DATE] revealed that Resident #47 was on a mechanical soft diet. Record review of Resident #47's care plan dated [DATE] did not have any information on his diet. Record Review of the professional Imaging Physician Consult Summary dated [DATE] revealed the reason swallow study was done was because of choking and swallowing issues. Recommendations were done. Resident was diagnosed with Oropharyngeal Dysphagia (swallowing difficulties). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN C's Resident #47's progress notes dated [DATE] revealed that the resident was eating supper. Resident stood up reached for his throat signs of chocking. RN started the Heimlich Maneuver to resident. Tried to take food out from his mouth and some dislodged from resident's throat. Called 911 then Resident #47 passed out RN started CPR. An interview with the DON on [DATE] at 8:55 AM revealed that the DON did not report the incident. The DON stated they were back and forth on rather the facility needed to report the incident. He stated that the nurse and CNAs were in the dining room. He stated that the nurse started the Heimlich and CPR and did everything needed until EMS arrived. He stated it was not unusual for someone to die from choking. The DON also stated that an investigation was not done due to the incident being witnessed. An interview with the ADM on [DATE] at 9:06 AM revealed that he did not report the incident because he was back and forth on rather it should be reported. He stated it was witnessed and it was not unusual. Interview with the DON on [DATE] at 12:30 PM revealed that Resident #47 had some teeth missing, did not have dentures and that the resident was able to chew food. He stated the resident did not have issues with swallowing. An interview with RN A on [DATE] at 2:26 PM revealed that he was in the dining room for dinner. He stated the Resident #47 stood up and did the universal sign of choking. He went over to the resident and started doing the Heimlich maneuver. He stated that Resident #47 then went to the floor. He stated he and LVN C swiped his mouth to get the food out. He stated he started doing CPR and that he was not sure if the resident was breathing or not at that time. He stated that he did not know if the resident had a diagnosis of swallowing difficulty. He also stated he did not know what type of diet the resident was on as he was not a resident he worked with. An interview with LVN C on [DATE] at 2:39 PM revealed that Resident #47 started choking at dinner and a staff member called her to the dining room. She stated she then started helping RN. She stated she called 911 and was sweeping food out of the resident's mouth. She stated that he suddenly passed out. She stated they followed instructions from EMS and EMS took over when they got to the facility. She stated Resident #47 was one of her regular resident's. She stated he was on a mechanical soft diet. She also stated that he had a swallow study done but was not sure what year. She stated the swallow study was normal. She stated Resident #47 would hold his food in his mouth. She also stated he was substantial risk for choking. She stated the resident did not have a diagnosis of difficulty swallowing because the test did not show anything wrong. An interview with the Speech Pathologist on [DATE] at 4:12 PM revealed that the resident came in with a diagnosis of swallowing difficulties. She stated the purpose of the swallow test was to get more specific as to which type of difficulty the resident was having. She stated that he was diagnosed with Oropharyngeal Dysphagia (which is a difficulty emptying part of the throat). She stated they did make recommendations for the resident based on his results. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #47's Primary Doctor on [DATE] at 4:31 PM revealed that the resident did not have a swallowing disorder. He stated he had been seeing the resident for two years. He stated he did not know why he ordered the swallow study. He stated the resident did not have any events of aspiration. When asked why he did not follow the recommendations of the swallow study he stated we treat the patient not the lab results. He did not have any issues swallowing. An interview with the Nurse Practitioner on [DATE] at 7:25 PM revealed that she thought the swallow study was done due to the resident losing weight. She stated that when labs come back LVN A would inform her if something was abnormal. She stated if there was not something abnormal, she would see the resident on Mondays or Fridays. She stated that she did not know why the swallow study was done or the results of the test. Record review of Reporting to HHSC Policy dated [DATE] revealed if a death under unusual circumstances needed to be reported immediately but not later than 24 hours after the incident occurs or is suspected.

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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 - Immediate jeopardy to resident health or safety 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** 49097 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 5 of 5 residents (Resident #43, Resident #47 , Resident #52, Resident #57, and Resident #67) reviewed for comprehensive care plans. These failures could place residents at risk of not having individual needs met, a decreased quality of life, causes residents not to receive needed services and death. 1. The facility failed to ensure Resident #47's care plan was comprehensive and updated to reflect he needed assistance with feeding and was a choking risk. An IT was identified on [DATE] at 12:00 PM. The IT template was provided to the facility on [DATE] at 12:47 PM. The IT was removed on [DATE], the facility remained in violation at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate because the facility failed to add the diagnosis of Dysphagia and Resident #47 had swallowing difficulty that required monitoring. Resident #47 passed away. 2. The facility failed to ensure Resident #52's care plan was comprehensive and updated to reflect his refusal of ADL care including interventions and timelines. 3. The facility failed to ensure Resident #57's care plan was comprehensive and updated to reflect his behaviors including interventions and timelines. 4. The facility failed to ensure Resident #43, and Resident #67's care plan was comprehensive and updated to reflect that the residents were smokers including interventions and timelines. Findings include: Record review of Resident #47's admission record dated [DATE] revealed Resident #47 was a [AGE] year-old male admitted on [DATE] with diagnoses of Nausea with vomiting, depressive disorder, reflux, high level of fat particles in the blood, Urinary tract infection, brain disease, vitamin D deficiency, pre-diabetes, constipation, dementia, inflammatory disorder of the pancreas, sleeping disorder, Alzheimer's, lack of coordination, muscle weakness, and communication difficulty. Record review of Resident #47's care plan last revised [DATE] revealed no documented/ identified problem with swallowing or choking. Resident #47's care plan did not have any diet information and did not have the diagnosis oropharyngeal dysphagia (swallowing disorder that affect the mouth and throat). Record review of Resident #47's quarterly MDS dated [DATE] revealed that the diagnosis of dysphagia and difficulty swallowing was not added to the residents MDS or care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #47's chart revealed that the resident had a swallow study done on [DATE]. The swallow study revealed that the resident had oropharyngeal dysphagia . The test also revealed that the resident was a choking risk. The resident function abilities were mild/moderate assistance- requires assistance with feeding. The swallow study report also stated that the Resident #47's dysphagia severity was severe given the risk factor for aspiration, aspiration pneumonia and/or choking. No physician orders were found by facility or in resident's chart. Record Review of the professional Imaging Physician Consult Summary dated [DATE] revealed the reason swallow study was done was because of choking and swallowing issues. Recommendations were done. Resident was diagnosed with Oropharyngeal Dysphagia (swallowing difficulties). Record review of LVN C's Resident #47's progress notes dated [DATE] revealed that the resident was eating supper. Resident stood up reached for his throat signs of chocking. RN started the Heimlich Maneuver to resident. Tried to take food out from his mouth and some dislodged from resident's throat. Called 911 then Resident #47 passed out RN started CPR. An interview with the DON on [DATE] at 8:55 AM revealed that the DON did not report the incident. The DON stated they were back and forth on rather the facility needed to report the incident. He stated that the nurse and CNAs were in the dining room. He stated that the nurse started the Heimlich and CPR and did everything needed until EMS arrived. He stated it was not unusual for someone to die from choking. The DON also stated that an investigation was not done due to the incident being witnessed. An interview with the ADM on [DATE] at 9:06 AM revealed that he did not report the incident because he was back and forth on rather it should be reported. He stated it was witnessed and it was not unusual. Interview with the DON on [DATE] at 12:30 PM revealed that Resident #47 had some teeth missing, did not have dentures and that the resident was able to chew food. He stated the resident did not have issues with swallowing. An interview with RN A on [DATE] at 2:26 PM revealed that he was in the dining room for dinner. He stated the Resident #47 stood up and did the universal sign of choking. He went over to the resident and started doing the Heimlich maneuver. He stated that Resident #47 then went to the floor. He stated he and LVN C swiped his mouth to get the food out. He stated he started doing CPR and that he was not sure if the resident was breathing or not at that time. He stated that he did not know if the resident had a diagnosis of swallowing difficulty. He also stated he did not know what type of diet the resident was on as he was not a resident he worked with. An interview with LVN C on [DATE] at 2:39 PM revealed that Resident #47 started choking at dinner and a staff member called her to the dining room. She stated she then started helping RN. She stated she called 911 and was sweeping food out of the resident's mouth. She stated that he suddenly passed out. She stated they followed instructions from EMS and EMS took over when they got to the facility because he had expired. She stated Resident #47 was one of her regular resident's. She stated he was on a mechanical soft diet. She also stated that he had a swallow study done but was not sure what year. She stated the swallow study was normal. She stated Resident #47 would hold his food in his mouth. She also stated he was substantial risk for choking. She stated the resident did not have a diagnosis of difficulty swallowing because the test did not show anything wrong. (continued on next page)

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	676291	A. Building B. Wing	07/17/2024

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Speech Pathologist on [DATE] at 4:12 PM revealed that the resident came in with a diagnosis of swallowing difficulties. She stated the purpose of the swallow test was to get more specific as to which type of difficulty the resident was having. She stated that he was diagnosed with Oropharyngeal Dysphagia (which is a difficulty emptying part of the throat). She stated they did make recommendations for the resident based on his results. An interview with Resident #47's Primary Doctor on [DATE] at 4:31 PM revealed that the resident did not have a swallowing disorder. He stated he had been seeing the resident for two years. He stated he did not know why he ordered the swallow study. He stated the resident did not have any events of aspiration. When asked why he did not follow the recommendations of the swallow study he stated we treat the patient not the lab results. He did not have any issues swallowing. An interview with the Nurse Practitioner on [DATE] at 7:25 PM revealed that she thought the swallow study was done due to the resident losing weight. She stated that when labs come back LVN A would inform her if something was abnormal. She stated if there was not something abnormal, she would see the resident on Mondays or Fridays. She stated that she did not know why the swallow study was done or the results of the test. Record review of Reporting to HHSC Policy dated [DATE] revealed if a death under unusual circumstances needed to be reported immediately but not later than 24 hours after the incident occurs or is suspected. Record review of Resident #52's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of other specified diabetes mellitus with hyperglycemia (condition caused by high blood sugar), other schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), bipolar disorder (mental illness characterized by extreme mood swings)-current episode depressed-mild, impulse disorder-unspecified, and drug induced subacute dyskinesia (uncontrolled, involuntary movements of the face, arms, and legs). Record review of Resident #52's annual MDS assessment dated [DATE] revealed a BIMS score of 9 meaning moderate cognitive impairment. Resident #52 is independent with ADLs. Record review of Resident #52's care plan last revised [DATE] revealed bathing section requires staff assistance with the goal to bathe independently and interventions bathing: one person assist, give verbal cues to help prompt, break tasks up into smaller steps, allow rest breaks between tasks. Record review of Resident #52's care plans updated on [DATE] revealed no care plan to address his resident refusing assistance with bathing. Record review of Resident #52's nurse progress notes dated [DATE] entered by the DON revealed: [Resident #52] attended his quarterly care plan meeting, emphasized, and reeducated the need to have a shower, have haircut and trim his fingernails- the resident denied all. When social worker talked to him about germs and how it will get him sick [Resident #52] said cannot understand the relationship despite how simple the social worker explained it to him. Also tried to incorporate bible reading on how cleanse body is good but [Resident #54] is not convinced. Asked what is in the shower/water he is afraid of; said he could not tell us. Gave a suggestion like taking a shower using a bucket, still said no. Asked if I could trim his fingernails resident said nope, will monitor for non-compliance. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of RN A notes of Resident #52's IDT meeting notes dated [DATE] revealed: Resident remains in stable condition, full code, resident ambulates without issue, extremely fast pace, brisk gait. Resident can communicate desires or requests. Generally, communication to staff evolves around the requesting of paper or foods. Resident alert and oriented to self and environment. Resident denies pain or discomfort. Resident is continent of bowel and bladder. Resident spends most of the time in room, while stationary sits and rocks back and forth in bed sometimes laughing to self. Resident suffers from delusions and hallucinations. Residents' hygiene is moderate to poor and remains challenge for staff to endorse. Resident consistently and adamantly refuses and rejects shower or management/ grooming of hair. Resident may become belligerent if he feels pressure in the forementioned areas of hygiene. Continue to manage as directed. An observation and interview on [DATE] at 10:17 AM with Resident #52, he was observed with unkempt hair that appeared dull and soiled, clothing both green shirt and pants appeared soiled and stained with a dark unknown dry substance. Resident #52 was not wearing shoes and had white socks on that appeared dark from dirt and his nails were observed dark underneath. A strong foul odor was also detected from Resident #52. Resident #52's mood appeared well and pleasant, he stated he was getting ready to go for a smoke break. Resident #52 stated that he gets the help that he needs from staff and when asked about showers/ baths he stated he did not want any. Resident #52 stated that he did not like baths or showers and did not want to receive one. He stated that he can change his own clothing and did not want to change it. An observation on [DATE] at 09:00 AM Resident #52 was wearing the same soiled green shirt and pants observed on [DATE]. Resident #52 was observed during his morning smoke break and mood appeared well. An observation and interview on [DATE] at 04:21 PM Resident #52 were still wearing the same green shirt and pants he was observed in on [DATE] and [DATE]. Resident #52 was observed ambulating in the hall and into his room, his mood appeared pleasant and when asked if he wanted to shower Resident #52 stated no. An interview on [DATE] at 02:31 PM with LVN B, she stated all staff have encouraged Resident #52 to take a shower and change his clothing and he refuses. LVN B stated the resident's guardian was aware and has been a part of the meetings in the past. LVN B stated that she has asked Resident #52 why he does not like showers or water, and she said he alluded to something happening in his past. She stated they do not pressure him into showering because it was his right not to if he decides and he will also become aggressive if staff push too hard on the subject. Record review of Resident #57 face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs), opioid dependence with unspecified opioid induced disorder, altered mental status-unspecified, and unspecified dementia (a group of symptoms that affects memory thinking and interferes with daily life)- unspecified severity-with other behavioral disturbance. (continued on next page)

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	676291	A. Building B. Wing	07/17/2024

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #57's admission MDS assessment dated [DATE] revealed BIMS section C0100: should resident interview be conducted was marked No. (resident is rarely/ never understood). Resident's BIM score was a 99 indicating resident was rarely/never understood. MDS assessment section GG- toileting revealed setup or cleanup assistance- helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity. Toilet transfer section revealed, independent- resident completes the activity themselves with no assistance from helper. Record review of Resident #57's care plan last revised [DATE] revealed no documented/ identified problem with mood/ behavior or interventions. Record review of LVN E's notes for Resident #57's IDT note dated [DATE] 08:02 AM revealed, resident up walking in his room after disrobing, made several attempts to put his clothes back on but became combative; redirected but resident became combative and started hitting at the staff will continue to monitor. Record review of LVN E's notes for Resident #57's IDT note dated [DATE] 08:13 AM revealed resident taken to the bathroom, voided without difficulty- approximately 20 minutes later resident went into a female resident's room pulled his pants down and brief down and voided on the floor. When instructed that he could not go into the females' room he told staff to kiss his ass. Attempt to put him in bed he would not allow it. Record review of RN A's notes for Resident #57's IDT note dated [DATE] 06:02 PM revealed, while resident was outside on the scheduled smoke break without warning resident stood up out of wheelchair and urinated on sidewalk. When staff suggested that the bathroom inside be used as it was the policy, resident stated, 'I can do whatever the hell I want' resident then sat back in wheelchair and ignored staff prompting. Record review of RN A's notes for Resident #57's IDT note dated [DATE] at 11:00 PM revealed, residents behavior remains challenging to manage. At the beginning of the shift resident refused assistance while in the room lying on padded floor. Record review of LVN E's notes for Resident #57's IDT note dated [DATE] at 12:39 AM revealed, resident in bed attempting to get out unassisted, removed is brief and threw it on the floor; when trying to clean him up put on another brief and resident started striking out at the aides. Record review of LVN B's notes for Resident #57's IDT note dated [DATE] 08:43 AM revealed, resident not easily redirectable, went into two rooms and voided on the floor .refuses assistance to bathroom, began cussing when attempted to assist. An observation and interview on [DATE] at 12:47 PM in Resident #57's room, he was observed standing near his bedside with a puddle of what appeared to be urine, and which had an ammonia/ urine smell that was detected when walking into the room. LVN B was notified, and she stated that was a behavior that he frequently exhibited where he urinates in the room or in the hall. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on [DATE] with LVN B she stated that Resident #57 was new, and the physicians have adjusted his medications trying to get the correct therapeutic dose to control his behaviors. LVN B stated that she would expect his behaviors to be mentioned in the care plan because he does have behaviors of being combative to staff, refusing care, and urinating on the floor. She stated that the DON would be responsible for making any care plan updates or ensuring it was individualized. Record review of Resident #43's admission record dated [DATE] revealed a [AGE] year-old female who was admitted on [DATE]. Resident #43's diagnoses included schizoaffective disorder (mental health mood disorder), other mental disorders, muscle wasting, lack of coordination, sleep disorder, alcohol abuse with alcohol-induced sexual dysfunction, vitamin D deficiency, dementia (forgetfulness, limited social skills and thinking ability), long term use of birth control (current), restlessness and agitation, marijuana abuse, carbuncle of chest wall (boils under the skin that are connected to each other), Hyperlipidemia (high levels of fat particles in the blood), psychosis (disconnection from reality), diabetes, hypercholesterolemia (high levels of cholesterol in the blood), hypertension (high blood pressure), cocaine abuse, abnormalities of gait and mobility. Record review of Resident #43's care plan, dated [DATE], did not reflected Resident #43 was a smoker. Record review of Resident #43's quarterly MDS dated [DATE] revealed Resident #43 had a BIM score of 15, indicating the resident could understand and make self-understood. Resident #47's MDS did not reveal she was a smoker. Record review of Resident #43's smoking assessment dated [DATE] revealed resident was able to smoke with staff supervision. The assessment also has that the care plan has been updated as appropriate. Record review of Resident #67's admission record dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #67's diagnoses included impulse disorder, insomnia (sleep difficulty), psychosis (disconnection from reality), schizoaffective disorder (mental health mood disorder), adjustment disorder with mixed anxiety and depressed mood, brain damage. Record review of Resident #67's care plan, dated [DATE], did not reflected Resident #67 was a smoker. Record review of Resident #67's quarterly MDS dated [DATE] revealed that Resident #67 had a BIMs score of 5, indicating Resident #67 rarely understands and is not able to make self-understood. Record review of Resident #67's smoking assessment dated [DATE] revealed resident was able to smoke with staff supervision. The assessment also has that the care plan has been updated as appropriate. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on [DATE] at 02:54 PM with the DON , he stated it was his responsibility to update the care plans. He stated that Resident #57's behavior has gotten better since the last adjustment on his medications. He stated that they have implemented interventions that were a part of the IDT meeting and in the IDT notes and did not think it needed to be added to the care plan. The DON said that Resident #52 has been spoken to many times about showers, but he refuses them, and it was his right to refuse. He stated that they still try to recommend many ways to get him clean and that sometimes he does agree to use wet wipes to clean his body. The DON then stated that his expectations were that the care plans were holistic and should reflect behavioral issues and the individualized needs of the residents. The DON said that if care plans were not updated there was potential for residents to not have their needs met. An interview on [DATE] at 03:30 PM with the ADM he stated it was his expectation that care plans were patient centered, he said if there was a pattern of repeated behaviors or have other needs that staff should be aware of that information should be care planned. The ADM said the IDT contributes to the care plan, but it was ultimately the responsibility of the DON to finalize it and update it as needed. The ADM said that a negative outcome of not having the care plan updated would be that care staff would not know the whole picture and be able to treat the resident. He said once something was addressed on the care plan it was addressed appropriately and you can meet the needs of the resident. Review of the facility care planning policy dated [DATE] revealed: Policy: to ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The facility will develop a person-centered baseline care plan for each resident. The care plan will be updated to reflect changes in the residents' condition or needs occurring prior to the development of the comprehensive care plan. Care plan will include measurable objectives and timetable to meet a resident medical, nursing, mental, and psychosocial needs. IT was removed on [DATE] at 6:00 PM and ADM was informed IT was removed. However, the facility remained out of compliance at a severity of no at no actual harm with the potential for more than minimal harm due that is not immediate jeopardy at a scope of isolated. The facility's plan of removal was accepted on [DATE] at 08:26 AM and reflected the following: On [DATE] a survey was initiated at facility. On [DATE] the surveyor provided an Immediate Jeopardy Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of immediate Jeopardy states as follows: F656- The facility failed to ensure Resident #47's care plan was comprehensive and updated to reflect he needed assistance with feeding and was a choking risk. (continued on next page)

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	07/17/2024

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This failure could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. -Action: A care plan audit was conducted and completed by DON for all residents with swallowing difficulties who have had a barium swallow test done and triggered for needing assistance with feeding or for choking risk to ensure no additional residents are at risk. Five residents triggered. Care Plans will be updated to reflect appropriate diet and interventions are in place and MDS will be checked to ensure swallowing issues and any modified diets are reflected accurately for those residents as well that trigger. Start Date: [DATE]. Completion Date: [DATE] Responsible: DON -Action: DON was reeducated by Clinical Nurse Consultant on care plans and ensuring they are kept updated as needed to reflect appropriate diet and interventions are in place. Start Date: [DATE]. Completion Date: [DATE] Responsible: Clinical Nurse Consultant -Action: Care Plans will be reviewed weekly by IDT and monitored weekly by DON to ensure reflective of resident's current clinical status and updated and communicated accordingly. The monitoring will be reported by the DON to the QAPI monthly for 3 months and as needed thereafter. Start Date: [DATE]. Completion Date: [DATE] Responsible: DON -Action: An Ad-hoc QAPI meeting was held by DON, MD, and Administrator regarding auditing and updating comprehensive care plans for residents that trigger for needing assistance with feeding and choking risk as well as monitoring of these residents during mealtime. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: [DATE]. Completion Date: [DATE] Responsible: DON Monitoring Included: An interview with CN on [DATE] at 1:13 PM revealed she in serviced the DON covered care plan diets, swallow studies, residents risk of choking, training the staff, interventions, and responsibilities. She stated she also trained him to train the other staff. An interview with ADM on [DATE] at 2:00 PM revealed that the ADM and DON went through the residents charts. The ADM stated they checked the residents charts to ensure if they were triggered for swallowing difficulties he could look and see if they needed assistance or supervision. He stated he made sure the DON added the risks and appropriate supervision on the resident's chart. He stated that was the process they did for the audit of the care plans. An interview with the DON on [DATE] at 2:10 PM revealed that he was trained on choking hazard, interventions, and responsibilities. He stated if a resident is choking staff are to do the Heimlich maneuver. He stated staff and himself are to monitor the residents who triggered for choking closely. He stated all care plans for those residents who triggered for choking hazard or swallowing difficulties have been updated to reflect the issue. Record Review of Resident's who triggered for swallowing difficulties and choking hazards revealed that their charts reflected the swallowing difficulty and choking risk. Record review of in-serviced training done for the DON revealed he had been trained on choking hazards and responsibilities. Record Review of QAPI revealed the facility did have a meeting and addressed the choking, and care plans. Record review of daily monitoring of residents of high-risk choking log dated [DATE] revealed the facility started monitoring on [DATE] at dinner. Record Review of the resident's charts that triggered for high-risk of choking were reviewed to ensure they had the correct diagnosis, choking difficulty and that they needed assistance with feeding. Record review of in-serviced training done by the DON revealed he had trained 27 of 38 staff on choking hazards and responsibilities. He stated that the remaining staff will be trained before they are allowed to work their next shift. IT was removed on [DATE] at 6:00 PM and ADM was informed IT was removed. However, the facility remained out of compliance at a severity of no at no actual harm with the potential for more than minimal harm due that is not immediate jeopardy at a scope of isolated. 49099

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	07/17/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #47) of 5 residents reviewed for accidents. The failed to ensure resident #47 was being monitored during meal intake resulting Resident #47 choking and ultimately passing away. This failure could result in other residents not getting the assistance or the supervision needed when they have swallowing difficulties and could also lead to severe injury and/or death. An IT was identified on [DATE] at 12:00 PM. The IT template was provided to the facility on [DATE] at 12:47 PM. The IT was removed on [DATE], the facility remained in violation at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate because the facility failed to Findings included: Record review of Resident #47's face sheet dated [DATE] revealed Resident #47 was a [AGE] year-old male admitted on [DATE] with diagnoses of Nausea with vomiting, depressive disorder, reflux, high level of fat particles in the blood, Urinary tract infection, brain disease, vitamin D deficiency, pre-diabetes, constipation, dementia, inflammatory disorder of the pancreas, sleeping disorder, Alzheimer's, lack of coordination, muscle weakness, and communication difficulty. Record review of Resident #47's quarterly MDS dated [DATE] revealed resident did not have a swallowing issue. The MDS also revealed the resident was on a mechanically altered diet (chopped/cut up food that are soft and easy to eat) Resident #47's MDS also revealed that resident was independent when feeding. Record Review of Resident #47's care plan dated [DATE] revealed no information as to Resident #47 having dysphasia (swallowing difficulty), needing assistance with feeding, or was at risk of choking. Record review of a professional Imaging Physician Consultation Evaluation and Management report dated [DATE] for Resident #47 revealed the chief complaint was choking, feeding difficulties, difficulty swallowing, poor intake and weight loss. The report also revealed the resident had the issues for weeks and the intensity was moderate. The evaluation also revealed that the resident was at risk for choking episodes and a diagnosis of oropharyngeal dysphagia (swallowing difficulty) was given. The report also stated that the resident needed assistance with feeding. Record review of the Dietary orders dated [DATE] revealed that Resident #47 was on a mechanical soft diet. No doctor orders for mechanical soft diet were received up on exit. Record review of Resident #47's care plan dated [DATE] did not have any information on his diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of LVN F's progress notes for Resident #47 dated [DATE] at 12:44 PM revealed requesting diet change. Appearing to be having problems swallowing. Consult with physician. Record review of LVN G's progress notes for Resident #47 dated [DATE] at 5:13 AM revealed request for diet change due to swallowing problems. Record review of LVN C progress notes for Resident #47's dated [DATE] revealed that the resident was eating supper. Resident stood up reached for his throat signs of chocking. RN started the Heimlich Maneuver to resident. Tried to take food out from his mouth and some dislodged from resident's throat. Called 911 then Resident #47 passed out RN started CPR. She stated that EMS pronounced the resident dead. Interview with the DON on [DATE] at 12:30 PM revealed that Resident #47 had some teeth missing, did not have dentures and that the resident was able to chew food. He stated the resident did not have issues with swallowing . He stated he had been the DON for a little over a year. He stated the nurse would let the doctor know when results come in and inform the doctor. He stated he did not know why the swallow study showed he had swallowing difficulties because he did not have any issues with swallowing. An interview with RN on [DATE] at 2:26 PM revealed he had been working at the facility for one year. He stated that he was in the dining room for dinner on [DATE] at approximately. 5:00 PM . He stated Resident #47 stood up and did the universal sign of choking. He went over to the resident and started doing the Heimlich maneuver. He stated that Resident #47 then went to the floor. He stated he and LVN swiped his mouth to get the food out . He stated a little chunk that was mushy came out. He stated he started doing CPR and that he was not sure if the resident was breathing or not at that time. He stated that he did not know if the resident had a diagnosis of swallowing difficulty. He also stated he did not know what type of diet the resident was on as he was not a resident, he worked with . He stated Resident #47 was given a mechanical soft diet that day. An interview with LVN on [DATE] at 2:39 PM revealed that Resident #47 started choking at dinner on [DATE] and a staff member called her to the dining room. She stated she then started helping RN. She stated she called 911 and was sweeping food out of the resident's mouth. She stated it was a ball of mush She stated that he suddenly passed out. She stated they followed instructions from EMS and EMS took over when they got to the facility. She stated Resident #47 was one of her regular resident's. She stated he was on a mechanical soft diet and given a mechanical soft diet the day he choked. She also stated that he had a swallow study done but was not sure what year. She stated the swallow study was done because the family was concerned . She stated the swallow study was normal. She stated Resident #47 would hold his food in his mouth. She stated she did not know how long he had been holding food in his mouth. She also stated he was high risk for choking. She stated the resident did not have a diagnosis of difficulty swallowing because the test did not show anything wrong. An interview with the Speech Pathologist on [DATE] at 4:12 PM revealed that the resident came in with a diagnosis of swallowing difficulties. She stated the purpose of the swallow test was to get more specific as to which type of difficulty the resident was having. She stated that he was diagnosed with Oropharyngeal Dysphagia (which is a difficulty emptying part of the throat). She stated they did make recommendations for the resident based on his results. (continued on next page)

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	676291	A. Building B. Wing	07/17/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #47's Primary Doctor on [DATE] at 4:31 PM revealed that the resident did not have a swallowing disorder. He stated he had been seeing the resident for two years. He stated he did not know why he ordered the swallow study. He stated the resident did not have any events of aspiration. When asked why he did not follow the recommendations of the swallow study he stated we treat the patient not the lab results. He did not have any issues swallowing. An interview with the Nurse Practitioner on [DATE] at 7:25 PM revealed that she thought the swallow study was done due to the resident losing weight. She stated that when labs come back LVN A would inform her if something was abnormal. She stated if there was not something abnormal, she would see the resident on Mondays or Fridays. She stated that she did not know why the swallow study was done or the results of the test. Record review of laboratory protocol and procedures dated [DATE] revealed that laboratory procedures will be done in accordance with facility policy and procedures. Requested policy for following up on swallow study results and notifying doctor and policy for supervising resident with swallowing difficulties who are at risk of choking, from the ADM and DON on [DATE] at 2:30 PM no policy was provided at the time of exit. The facility's plan of removal was accepted on [DATE] at 08:26 AM and reflected the following: On [DATE] a survey was initiated at facility on [DATE] the surveyor provided an Immediate Jeopardy Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of immediate Jeopardy states as follows: F689 - The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents in that: They failed to ensure resident was being monitored during meal intake resulting in severe injury, and death. -Action: An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on monitoring residents during meal service who need assistance with feeding and that trigger for choking risk as well as communicating updated interventions and staff responsibilities, prior to them working the floor. All staff were re-educated on the regulatory guidelines and facility policy and procedures regarding Abuse, Neglect and Exploitation. Start Date: [DATE]. Completion Date: [DATE] Responsible: DON (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Action: DON was reeducated on monitoring residents during meal service who need assistance with feeding and that trigger for choking risk as well as communicating updated interventions and staff responsibilities, prior to them working the floor. Start Date: [DATE]. Completion Date: [DATE] Responsible: Clinical Nurse Consultant -Action: DON or designee will do weekly checks during meals to ensure staff are monitoring residents who need assistance with feeding and that trigger for choking risk. This will be documented on a QAPI monitoring form and reported to QAPI monthly for 3 months and as needed thereafter. Start Date: [DATE]. Completion Date: ,d+[DATE] Responsible: DON -Action: An Ad-hoc QAPI meeting was held by DON, MD, and Administrator regarding auditing and updating comprehensive care plans for residents that trigger for needing assistance with feeding and choking risk as well as monitoring of these residents during mealtime. Start Date: [DATE]. Completion Date: [DATE] Responsible: DON Monitoring included. An interview with CN on [DATE] at 1:13 PM revealed she in serviced the DON covered care plan diets, swallow studies, residents risk of choking, training the staff, interventions, and responsibilities. She stated she also trained him to train the other staff. An interview with ADM on [DATE] at 2:00 PM revealed that the ADM and DON went through the residents charts. The ADM stated they checked the residents charts to ensure if they were triggered for swallowing difficulties he could look and see if they needed assistance or supervision. He stated he made sure the DON added the risks and appropriate supervision on the resident's chart. He stated that was the process they did for the audit of the care plans. (continued on next page)

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	676291	A. Building B. Wing	07/17/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN A on [DATE] at 2:50 PM revealed he had been trained on hazards of choking on [DATE]. He stated the training covered choking monitoring and risk for choking. He stated that if someone is choking, they would naturally reach for their throat. He stated it is important to ensure the resident has oxygen and can breathe during the choking and after. He also stated if a resident is choking it is important to try to get their airway clear. He stated he was trained on abuse and neglect and resident rights. He stated the training covered the rights of the resident and who to report abuse and neglect to and how to identify abuse. An interview with LVN C on [DATE] at 3:02 PM revealed that she had been trained on choking and hazard of choking on [DATE]. She stated the training covered what to do if a resident is choking. She stated there were to be a nurse in the hall and a nurse in the dining room monitoring the residents. she stated if a resident was choking staff were to do the Heimlich maneuver and remove the food from their throat. She stated she had been trained on resident rights and abuse. She stated that the training covered who to report abuse to what to do if you suspect abuse and making sure staff are meeting the needs of the resident. An interview with CNA H on [DATE] at 3:10 PM revealed he had been trained on choking hazards and monitoring on [DATE]. He stated the training covered watching the residents during mealtime, watch the way the resident is eating and ensure resident are not having issues. He stated that if a resident were choking, he would help the resident and let the nurse know. He stated he was trained on resident rights and abuse. He stated the training covered the residents rights to refuse care and move around the facility. He stated if a resident is being abused, he would report it to the administrator. An interview with the Dietary manager on [DATE] at 3:38 PM revealed due to active COVID in the building, she brings the residents from one side of the building to the dining room at a time. She stated the residents that come to the dining room are the ones who need assistance. She stated for the residents who are at risk of choking she puts a red mark on their tray to let staff know they are at risk of choking. She stated those residents are the only ones brought to the dining room. Observation of dining services on [DATE] at 4:45 PM revealed that all resident that triggered for swallowing difficulties was in the dining room for observation while eating. One resident had COVID and was eating in his room, a staff member stood outside residents room to watch him. All residents who were triggered for choking risk were given the proper diet. Record review of in-serviced training done by the DON revealed he had trained 27 of 38 staff on choking hazards and responsibilities. He stated that the remaining staff will be trained before they are allowed to work their next shift. Record Review of QAPI revealed the facility did have a meeting and addressed the choking, and care plans. Record review of daily monitoring of residents of high-risk choking log dated [DATE] revealed the facility started monitoring on [DATE] at dinner. IT was removed on [DATE] at 6:00 PM and ADM was informed IT was removed. However, the facility remained out of compliance at a severity of no at no actual harm with the potential for more than minimal harm due that is not immediate jeopardy at a scope of isolated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on observation, interviews, and record review the facility failed to accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals for 1 of 1 resident (Resident #1) reviewed for pharmacy services and procedures in that: The facility failed to ensure medication administered to a resident #1 was properly administered and not left in the room. This failure could place residents at risk of not receiving their physician ordered medications resulting in a decreased quality of life. Findings include: Review of Resident #1's face sheet dated 06/27/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease-unspecified (brain disorder that causes problems with memory, thinking, and behavior), Parkinson's disease (disorder that affects the nervous system and causes movement problems), unspecified psychosis (condition of the mind that results in difficulties determining what is real and what is not) not due to a substance or know physiological condition, other schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), COPD (chronic inflammatory lung disease that causes obstructive airflow to lungs), and primary hypertension (high blood pressure). Review of Resident #1's quarterly MDS assessment dated [DATE] revealed BIMS section C0100: should resident interview be conducted was marked No. (resident is rarely/ never understood) Section I of the MDS assessment for active diagnosis was checked for psychotic disorder (other than schizophrenia) and Schizophrenia. Review of Resident #1's care plan last revised 03/28/2024 revealed I will have no injury related to medication usage/side effects with interventions: I need my medications as ordered. I want my pharmacy consultant to review my medications monthly. Refer me to psych services as needed. Review of Resident #1's physician orders revealed an order start date of 02/21/23 for Depakote ER 250 MG tablet, give 3 tablets = 750 MG PO at HS. Indication of use was for schizoaffective disorder. An observation and interview on 06/25/24 at 10:28 AM in Resident #1's room, a white pill was observed on the floor next to his dresser. An attempt was made to interview Resident #1, but he was not able to communicate clearly (refer to BIMS section of quarterly MDS assessment review). The pill was taken to the DON and in an interview with the DON he identified the medication as Depakote. The DON stated he was not sure how the medication ended up on the floor. The DON said it would have been the night MA who would have administered that medication to Resident #1. The DON said it was his expectation that when administering medication that staff wait and check to ensure oral medication was swallowed by the resident. The DON said a potential negative outcome to leaving medication unattended would be another resident could pick it up. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/27/24 at 01:05 PM with MA D he stated that he was the aide that administered the medication to Resident #1 on the night shift and remembers administering the Depakote to Resident #1 on the night of 06/24/24. MA D stated he waits and makes sure each resident takes their medications before he walks away to ensure they do not choke. MA D said medication should never be left unsupervised because another resident could wander in the room, take it, and have a potential allergic reaction to it. MA D said he was not certain how the medication was left behind and denied leaving it. An interview on 06/27/24 at 03:30 PM with the ADM he stated it was his expectation that staff follow the medication administration procedure when administering medication. He said medication should never be left behind unsupervised. The ADM said a potential negative outcome to leaving medication behind was it could fall into the wrong hands, another resident could take it, or the resident who needs it could have a negative outcome due to not taking their full prescribed dose. Review of the undated Medication Administration policy revealed: The facility will ensure that medication pass is within the one-hour window and all clients will be given their medication in a safe manner. - The care giver trained to give the medication will ensure that the seven rights of medication administration are followed: o Right client, right drug, right time, right dosage, right route, technique, documentation. - All medications must be stored in a locked cabinet, only the assigned caregiver properly trained will be able to unlock and give the mediations to the clients.