

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Oakcrest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interview, observation and record review the facility failed to maintain infection control practices during food preparation for 1 of 1 meal observed for meal preparation. The DS failed to maintain infection control practice by:1. The DS failed to complete hand hygiene appropriately.2. The DS failed to sanitize the thermometer with a clean alcohol swab between food items. 3. The DS failed to sanitize the thermometer after touching another surface with the thermometer. These failures could result in cross contamination or food allergies. Findings Include: An observation was conducted on 08/06/2025 at 11:25AM while the DS pureed the food for lunch. The DS had placed the chicken into the puree blender and completed the puree process. After the DS emptied the chicken out of the blender, the DS moved onto the next food item to puree. This process was continued through 3 more menu items at which the DS did not wash their hands in between food items. An observation was conducted on 08/06/2025 at 11:45AM while the DS took temperatures of the food items. The DS used an alcohol swab and a thermometer to check the temperatures. After each food item, the DS used the same alcohol swab to clean it off. The DS then used the same thermometer to pick up a lid and continue temperature checks on the food. An observation was made after temperature checks where the DS completed the hand washing process. The DS turned the water on, used soap to wash her hands, and then turned off the sink with her hand. The DS then grabbed a paper towel and dried her hands. An interview was conducted on 08/07/2025 at 1:06PM with the DS who stated they have worked at the facility since 1987. The DS described hand hygiene as turn on the water, wash your hands with soap, pull a paper towel out and turn off sink with the paper towel, not your hands. The DS stated that staff should wash their hands before starting puree, depending on the meat then they must wash their hands in between food items. The DS stated that temperature check should be to take the thermometer, clean it with an alcohol swab and clean it between menu items. The DS stated that they use the same alcohol swab every time. The DS stated that not properly cleaning the thermometer between food items could result in cross contamination. An interview was conducted on 08/07/2025 at 3:10PM with the DON who had worked at the facility since 2020. The DON stated the expectation for infection control in the kitchen was to make sure that the food was safe to eat. The DON described the process for handwashing in the kitchen as wash hands for 20 seconds with soap and water. The DON confirmed that staff should turn off the sink with a paper towel. The DON stated the expectation for temperature checks in the kitchen was to prevent infection control and reduce the potential for Micro-organisms to grow. The DON stated unproper hand hygiene and infection control practices could negatively impact a resident by the potential for cross contamination. An interview was conducted on 08/07/2025 at 4:00PM with the ADM who had worked at the facility for 2 years. The ADM stated the expectation for infection control in the kitchen was for staff to follow infection control practices. The ADM stated that the handwashing protocol in the kitchen should be staff wash their hands with soap and water and turn the faucet off with a paper towel. The ADM stated the expectation for temperature checks in the kitchen, to prevent infection control was to ensure that there was a clean wipe for every food item. The ADM stated that staff should not use the thermometer to pick up lids and continue temperature checks without sanitizing the thermometer (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	first. The ADM stated that could be an issue for infection control. The ADM stated that not following infection control practices in the kitchen could negatively impact a resident because the staff's hands could be contaminated. The ADM stated turning the faucet off with your hand instead of a paper towel defeats the purpose of washing their hands. RR of policy titled Food Safety dated 2006 reflect the following: 1. Provide food that is free from contamination thus risking the health and wellbeing of the residents and staff. 2. Food will be served in such a way to prevent bacteria growth.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish a person-centered care plan for 3 of 3 (Resident #52, Resident #7 and Resident #35) residents reviewed for care plans. The facility failed to ensure Resident #52, Resident #7 and Resident #35 had a person-centered care plan developed and implemented to meet the resident's medical, physical, mental and psychosocial needs, including the diagnosis of Dementia/Alzheimer's. This failure could result in residents not getting the specialized care that they need for their diagnosis. Findings Include: RR of Resident #52's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included Alzheimer's Disease (progressive brain disorder that gradually destroys memory and thinking skills), Cognitive Deficit Disorder (decline in a person's mental abilities, impacting their thinking, learning, memory, and other cognitive functions), and Generalized Anxiety Disorder. RR of Resident #52's Care Plan last updated 06/14/2025 reflected a diagnosis of Alzheimer's disease but failed to include a focus area and goal for an Alzheimer's diagnosis. RR of Resident #52's Annual MDS Record dated 04/19/2025 did not reflect a BIMS score. The MDS reflected Resident #52 had a Memory Problem and Severely Impaired Cognitive Skill. Record review of Resident #7's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included dementia (progressive decline in cognitive functions, such as memory, thinking, reasoning, language, and judgement, that interferes with daily life and independence), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), major depressive disorder (low mood), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), urinary tract infection, chronic pain, and cerebral infarction (history of a stroke). Record review of Resident #7's Quarterly MDS dated [DATE] did not reflect a BIMS Score. The MDS further reflected Resident #7 had a diagnosis of dementia and Alzheimer's disease. Record review of Resident #7's Care Plan, last revised on 07/18/25, reflected a diagnosis of dementia, but did not reflect a focus area of dementia or Alzheimer's disease. Record review of Resident #7's Order Summary Report dated 08/07/25 reflected an order to evaluate and treat by Psychiatrist, Psychiatric Services, and relevant prescribed medications as below: Abilify 15mg give 0.5 tablet by mouth one time a day for behavior. Escitalopram oxalate 10 mg 1 tablet by mouth daily for major depressive disorderRecord review of Resident #35's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included alcohol-induced dementia (A brain disorder caused by a person regularly drinking too much alcohol, or binge drinking over several years), cognitive communication deficit (deficit in ability to think or communicate), need for assistance with personal care, and muscle weakness. Record review of Resident #35's Quarterly MDS dated [DATE] did not reflect a BIMS Score. The MDS further reflected Resident #35 had a diagnosis of Non-Alzheimer's Dementia and anxiety disorder. Record review of Resident #35's Care Plan, last revised on 06/26/25, reflected a diagnosis of alcohol dependence with alcohol-induced persisting dementia, but did not reflect a focus area of dementia or Alzheimer's disease. Record review of Resident #35's Order Summary Report dated 08/07/25 reflected an order to evaluate and treat by Psychiatrist, Psychiatric Services, and diagnoses of cognitive communication deficit and alcohol dependence with alcohol-induced persisting dementia. Relevant prescribed d medications as below: Ativan 1mg 1 tablet by mouth three times per day for anxiety Divalproex Sodium 500mg 1 tablet by mouth two times per day for impulse control Olanzapine 10mg 1 tablet by mouth at bedtime for behavior controlAn interview was conducted on 08/07/2025 at 2:15PM with CNA A who had worked at the facility for 4 months. CNA A stated that they knew what a care plan was. CNA A stated a care plan was provided to all residents. CNA A stated the care plan tell staff what to do for the residents and who was responsible for the resident. CNA A stated they could find a diagnosis in the care plan. CNA A confirmed that the importance of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plans was to know how to specially focus on each individual resident and what their needs were. CNA A stated not having the diagnosis of Dementia/Alzheimer's in the care plan could negatively impact a resident by staff may not know how to treat the residents. An interview was conducted on 08/07/2025 at 2:35PM with LVN D who had worked at the facility for 1 year. LVN D stated a care plan was a plan that takes place with the family and resident to try and provide the proper care for the residents' needs according to their profile. LVN D stated you could find a diagnosis for the resident inside of the care plan. LVN D stated if a resident had dementia, it would be in the care plan under diagnosis. LVN D stated that this diagnosis should be specified so staff can provide the proper care for the resident. LVN D stated not having the resident's diagnosis in the care plan could negatively impact a resident because the facility would not be able to provide the proper care because they need to be able to identify the approach for every single resident. It is individualized to the patient's needs for proper and better care. An interview was conducted on 08/07/2025 at 3:10PM with the DON who had worked at the facility since 2020. The DON stated that the DON was responsible for care plans. The DON stated Medication, resident's risks, anything that they need such as smoker and behaviors could be found in the care plan. The DON stated there was diagnosis in the care plan as well. The DON stated that if a resident had dementia/Alzheimer's that should be documented in the care plan. The DON stated it was important for this diagnosis to be in the care plan so residents could be properly treated and addressed. The DON stated that there was no reason this diagnosis would this not be included in the care plan. The DON stated it could negatively impact a resident if this diagnosis was not in their care plan by the residents may not get the proper care they need. An interview was conducted on 08/07/2025 at 4:00PM with the ADM who had worked at the facility for 2 years. The ADM stated the DON oversees the resident's care plan. The ADM stated that he does review the care plans by the form of staff summarizing it to him. The ADM stated that you could find diagnosis in the care plan. The ADM then stated that if a resident had dementia, it would be in the care plan. The ADM stated that it was important for the diagnosis to be addressed in the care plan so that residents can get the proper care for that diagnosis that may come with it. The ADM stated not including this diagnosis in the care plan could negatively impact a resident by not receiving the proper care. RR of policy titled Care Planning dated 12/13/2020 reflect the following:1. To ensure that a comprehensive person-centered care plan is developed foreach resident based on their individual assessed needs.2. Care plan will include measurable objectives and timetable to meet a resident's medical, nursing, mental and psychosocial needs.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 5 of 7 residents (Resident #50, Resident #24, Resident #20, Resident #35 and Resident #11) reviewed for pharmaceutical services. The facility failed to document the administration of controlled medications from the medication cart on the narcotic count sheets for Resident #50, Resident #24, Resident #20, Resident #35 and Resident #11. This failure could place residents at risk of not receiving a therapeutic dosage of medication, drug diversion, and overdose. Findings include: Observation on 08/06/2025 at 11:33 AM during medication administration revealed LVN C was observed not signing out the controlled substances on the narcotic sheets for each resident: Resident #50 received Tramadol 50mg 1 tablet by mouth for pain, Resident #24 received Ativan 0.5mg 1 tablet by mouth for anxiety, Resident #20 received Tramadol 50mg 1 tablet by mouth for pain, and Resident #35 received Lorazepam 1mg 1 tablet by mouth for anxiety. Interview on 08/06/25 at 11:55 AM with LVN C revealed she had not signed the narcotic count sheets yet, and knew she was should have filled in and signed the narcotic count sheets right after removing the medication from the packaging. Observation on 08/06/2025 at 12:48 PM of gastrostomy tube medication administration for Resident #11 with LVN C revealed she did not sign out the controlled substances on the narcotic sheet for Resident #11. The controlled medication included Tramadol 50 mg 1 tablet per tube for pain. Interview on 08/06/25 at 1:10 PM with LVN E revealed she had worked in the facility for 17 years. LVN E stated she had prepared the Tramadol, Gabapentin and carbidopa-Levodopa for Resident #11, but had not yet signed the narcotic count sheets. LVN E further stated she was supposed to have signed the narcotic count sheets right after removing the controlled medications. Interview on 08/07/25 4:05 PM with the DON who stated the charge nurse, and the DON were responsible for ensuring opened medication bottles and other packages are labeled/dated. He further stated medication should be dated when opened, and unopened insulin should be kept in the refrigerator. He stated over the counter medications OTC bottles such as Mylanta should be dated when opened and disposed of within 30 days. The DON stated when supplements such as Med Pass 2.0 were opened, it should be stored on ice, dated, and discard after one day of use. He further stated if left opened and kept in cart it will go bad and make the residents sick. The DON stated a potential negative outcome to the residents when controlled substances are not signed out, and medications are not labeled with a date when opened was the resident could receive medication at the wrong time and could run out of medication. Record review of the facility's undated Medication Administration policy and procedure reflected, 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. Procedure: The caregiver trained to give medications will ensure that the seven rights of Medication Administration are followed: a. Right client b. Right drug c. Right timed. Right dosage e. Right route f. Right technique g. Documentation 6. Document all medications administered in their proper MAR.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards, including expiration dates for 1 (MR E) of 2 medication rooms and 1 (MC A) of 3 med carts reviewed for pharmaceutical services.1. A supplement drink named Med Pass 2.0 + was left opened and dated, and not on ice inside of MC A.2. Over the counter medications (OTC) that had been opened, had no date indicating when they were opened in MR E This failure could lead to medication not being effective, and therefore impacting resident health. Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards, including expiration dates for 1 (MR E) of 2 medication rooms and 1 (MC A) of 3 med carts reviewed for pharmaceutical services.1. A supplement drink named Med Pass 2.0 + was left opened and dated, and not on ice inside of MC A.2. Over the counter medications (OTC) that had been opened, had no date indicating when they were opened in MR E This failure could lead to medication not being effective and therefore impacting resident health. Findings included:Observation on 08/06/25 at 11:21 AM for medication administration observation with CMA A revealed a supplement drink named Med Pass 2.0 + was opened and dated, and not on ice inside of MC A. The Med Pass 2.0 + also was not dated properly. CMA A was not observed using the undated container of Med Pass 2.0 + during his medication administration.Interview on 08/06/25 at 11:21 AM with CMA A revealed he had not left the Med Pass 2.0 + in MC A, that it must have been the previous shift. CMA A further stated any supplements or puddings used during medication administration should be dated on opening and kept on ice for food safety purposes, otherwise it could make the residents sick.Observation on 08/06/2025 at 2:55PM in Med Room E revealed three over the counter medications (OTC) that had been opened but with no date indicating when they were opened, which included Pepto Bismol, Geri-Lanta and MiraLAX.Interview on 08/06/2025 at 2:55PM with LVN E revealed the bottled OTC medications (Pepto Bismol, Geri-Lanta, and MiraLAX), were used for multiple residents per physician orders, and nursing was supposed to write the date the bottle had been opened. LVN E further stated these medications were poured into a medication cup and then administered to the resident. Interview on 08/07/25 4:05 PM with the DON revealed the charge nurse, and the DON were responsible for ensuring opened medication bottles and other packages are labeled/dated. He further stated medication should be dated when opened, and unopened insulin should be kept in the refrigerator. He stated over the counter medications bottles such as Mylanta should be dated when opened and disposed of within 30 days. The DON stated when supplements such as Med Pass 2.0 were opened, it should be stored on ice, dated, and discard after one day of use. He further stated if left opened and kept in cart, it will go bad and make the residents sick.Interview on 08/07/25 4:05 PM with the DON who stated the charge nurse, and the DON were responsible for ensuring opened medication bottles and other packages are labeled/dated. He further stated medication should be dated when opened, and unopened insulin should be kept in the refrigerator. He stated over the counter medications OTC bottles such as Mylanta should be dated when opened and disposed of within 30 days. The DON stated when supplements such as Med Pass 2.0 were opened, it should be stored on ice, dated, and discard after one day of use. He further stated if left opened and kept in cart it will go bad and make the residents sick. The DON stated a potential negative outcome to the residents when controlled substances are not signed out, and medications are not labeled with a date when opened was the resident could receive medication at the wrong time and could run out of medication. Record review of the facility's Medication Storage Protocol dated 03/15/18 reflected, Protocol: All medications must be stored in the best possible way for safety both for residents and the facility.3. Ophthalmic, inhalers, all flushes, multiple dose vials including Insulin, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	irrigation solution and IV fluids must be marked with date opened or first used.8. Medication carts must be checked on a monthly basis, or more often, to be sure all medications are in date and have the required dating.Record review of the facility's undated Medication Administration policy and procedure reflected, 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.Procedure: The caregiver trained to give medications will ensure that the seven rights of Medication Administration are followed:a. Right clientb. Right drugc. Right timed. Right dosagee. Right routef. Right techniqueg. Documentation6. Document all medications administered in their proper MAR.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 5 of 7 residents (Resident #2, Resident #3, Resident #46, Resident #22, and Resident #52) reviewed for infection control. 1. The facility failed to ensure LVN E cleansed her hands by handwashing/hand hygiene with alcohol-based rub before and after blood sugar checks for Resident #2 and Resident #46. The facility failed to ensure CNA B was cleansing male residents properly and conducting hand hygiene and glove change during peri-care for Resident #22 and Resident #52.3. The facility failed to ensure LVN D were following prescribed Enhanced Barrier Precautions by not putting on a gown before providing wound care to Resident #3. These failures could place residents at risk of transmission of disease and infection. Findings included: Resident #2 Record review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes mellitus type 2, immunodeficiency, hyperlipidemia (elevated fats/lipids in the blood), chronic pain, hypertension (high blood pressure), difficulty in walking, and cognitive communication deficit. Record review of Resident #2's Comprehensive MDS assessment dated [DATE] reflected a BIMS Score of 15, which reflected no cognitive impairment. The MDS reflected Resident #2 had a diagnosis of diabetes mellitus type 2. Record review of Resident #2's Care Plan, last revised on 05/21/25, reflected a diagnosis of diabetes mellitus type 2. The Focus reflected Resident #2 has diabetes mellitus type 2, and the goal was to have no complications related to diabetes through review date. The interventions included to educate Resident #2/family/caregivers as to the correct protocol for glucose monitoring and insulin injections and obtain return demonstrations. Observation on 08/06/2025 10:31 AM of blood glucose check for Resident #2 revealed LVN E cleansed her hands with an alcohol-free premium adult wipe before and after blood sugar checks. Procure Premium adult washcloths are high-quality, disposable wipes designed for personal hygiene and cleansing. LVN E used an alcohol wipe for cleaning Resident #2's glucometer Resident #46 Record review of Resident #46's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes mellitus type 2, chronic kidney disease, hypertension, and urinary retention (difficulty emptying bladder). Record review of Resident #46's Order Summary Report dated 08/07/25 reflected orders for Insulin Regular Human injection solution 100 unit/mL, inject as per sliding scale: 151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301-350 = 8 units 351-400 = 10 units and call MD, subcutaneously before meals and at bedtime related to diabetes mellitus type 2 with hyperglycemia. Observation on 08/06/2025 10:43 AM of blood glucose check for Resident #46 revealed LVN E administered his insulin and cleansed her hands with alcohol-free adult washcloths between glove changes. Procure Premium adult washcloths are high-quality, disposable wipes designed for personal hygiene and cleansing. LVN E then used an alcohol pad for cleaning Resident #46's glucometer Resident #22 Record review of Resident #22's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included irritable bowel syndrome, dysphagia (difficulty swallowing), cognitive communication deficit, Huntington's disease (a genetic condition that affects the cells in your brain. It's a progressive condition that gets worse over time.), restlessness and agitation, and abnormalities of gait and mobility. Record review of Resident #22's Quarterly MDS dated [DATE] reflected Resident #22 used a manual wheelchair, and once seated in the wheelchair was able to wheel at least 150 feet in a corridor or similar space. The MDS further reflected Resident #22 was incontinent of bowel and bladder and required the assistance of two people to provide ADLs. Record review of Resident #22's Care Plan, last revised on 05/28/25, reflected an ADL self-care performance deficit related to confusion and disease process of Huntington's. The goal was to maintain current level of function (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with moderate assistance through the review date of 05/29/25. Interventions reflected Resident #22 was totally dependent on staff for repositioning and turning in bed every shift and as necessary. Resident #22 was bedfast all or most of the time. Observation on 08/06/2025 at 3:28 PM of peri-care for Resident #22 revealed CNA B was cleansing the penis from the base towards the meatus, and did not change gloves and conduct hand hygiene when going from the peri area to the bottom, or from front to back. Resident #52 Record review of Resident #52's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included Alzheimer's disease, restless and agitation, dysphagia (difficulty swallowing), lack of coordination, muscle weakness, and hypertension. Record review of Resident #52's Quarterly MDS dated [DATE] reflected no BIMS Score. The MDS reflected Resident #52 used a manual wheelchair, and once seated in the wheelchair was able to wheel at least 150 feet in a corridor or similar space. The MDS further reflected Resident #52 was incontinent of bowel and bladder and required the assistance of two people to provide ADLs. Record review of Resident #52's Care Plan, last revised on 08/05/25, reflected he received Hospice services. The goal reflected dignity will be maintained and Resident #52 will be kept comfortable and pain free within one hour of intervention. Interventions included assistance with ADLs and provide comfort measures as needed. Observation on 08/06/2025 at 4:22 PM of peri-care for Resident #52 revealed CNA B cleansed the front area from base of the penis towards the meatus and used the same wipe for cleaning the shaft and glans of the penis. CNA B then changed gloves without conducting hand hygiene and continued cleaning the front peri-care of Resident #52. CNA B then assisted Resident #52 to his side and continued cleaning his bottom without conducting hand hygiene or changing gloves. He then assisted Resident #52 with putting on a clean pull-up and pants and then assisted Resident #52 into his wheelchair. CNA B then changed gloves and conducted hand hygiene. Resident #3 Record review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes mellitus type 2, osteomyelitis (bone infection), acquired absence of left great toe, vascular dementia, hypertension, cerebral infarction (stroke), and muscle weakness. Record review of Resident #3's Quarterly MDS dated [DATE] reflected a BIMS Score of 4, which reflected severe cognitive impairment. The MDS reflected Resident #3 had a diagnosis of diabetes mellitus type 2. Resident #3's MDS further reflected a surgical wound that required surgical wound care, application of ointments/medications, and application of dressings to feet. Record review of Resident #3's Care Plan, last revised on 06/20/25, reflected he was at risk for infection related to wound to a left toe, and was placed on Enhanced Barrier Precautions. The goal was for Resident #3 to not exhibit any signs or symptoms of infection related to wound on left toe. Interventions included providing Enhanced Barrier Precautions for preventative measures, hand hygiene prior to and after direct care, and gowns, gloves and mask to be used when providing direct care. Review of Physician Orders for Resident #3 reflected treatment to left foot - daily dressing changes. Wash with wound wash then wrap with kerlix and ace wrap. Observation on 08/ 07 /25 at 9:10AM of wound care for Resident #3 revealed LVN D did not follow prescribed Enhanced Barrier Precautions by not putting on a clean gown or mask before conducting wound care for Resident #3. Interview on 08/07/25 4:05 PM with the DON revealed he had worked at the facility since 2020. He stated the Infection Preventionist was responsible for ensuring all staff were following infection control measures when providing care for the residents. The DON stated it was important for staff to disinfect surfaces and medical equipment when providing wound care, and peri-care should be conducted properly to reduce cross contamination. The DON further stated the use of handwashing should be conducted between each resident, and during care when going from clean to dirty, and the use of hand sanitizer was allowed up to 3 times between handwashing with soap and water. He stated a non-alcohol-based wipe was not appropriate for hand hygiene because they did not contain a disinfectant that killed germs. The DON stated a potential negative outcome for the residents was an infection for the resident. Review of the facility's policy and procedure on Handwashing, dated 2008 reflected: Purpose - Handwashing will be (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Oakcrest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9808 Crofford LN Austin, TX 78724	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarded by this facility as the single most important means of preventing the spread of infection.Procedure:1. All personnel will follow the facility's established handwashing procedures to prevent the spread of infection and disease to other personnel, residents, and visitors. 2. Hands should be washed ten (10) to fifteen (15) seconds under the following conditions:. b. Whenever hands are obviously soiledc. Before performing invasive proceduresd. Before preparing or handling medications.g. After contact with blood, body fluids, excretions, secretions, mucous membranes, or nonintact skin.j. After removing gloves.l. Whenever in doubt.Review of the facility's policy and procedure on Perineal Care, dated 2018 reflected: Basic responsibility of the Licensed Nurse and Certified Nursing AssistantPurpose: Cleanse the perineum Prevent infection and odorProcedure:3. Put on disposable glovesMale perineal caref. Gently wash pubis and penis. If uncircumcised, pull back foreskin and wash gently. Carefully dry and return foreskin to normal position. Make sure shaft of penis is dry.Review of the facility's undated policy and procedure on Enhanced Barrier Precautions reflected: This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within the facility by implementing Enhanced Barrier Precautions (EBP).Procedure:2. Nursing staff initiates Enhanced Barrier Precautions for residents with any of the following:a. Wounds or indwelling medical devices, even if the resident is not known to be infected or colonized with MDRO.Review of the facility's policy and procedure on Infection Control, dated 06/01/2018, reflected: Policy: This facility has established the Infection Control Policies and Procedures with the basic guidelines to follow to provide a safe, sanitary and comfortable environment for all residents and the employees as well.Goal: To help prevent the development and transmission of disease and infection in the community by following the CDC guidelines.Objective: 1. Investigate, control and prevent infections in the facility.2. Maintain a safe, clean, sanitary and comfortable environment for residents, employees, visitors and the general public.5. Establish guidelines to follow and implement Standard Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and non-intact skin.Procedure:1. This facility's Infection Control Policies and Procedures will apply equally to all personnel, resident, visitors, volunteer workers and the public.2. 2. It shall be the responsibility of the facility to inform personnel of the Infection Control Policies and Procedures through the Orientation Program and the regularly scheduled In-Service Programs as required by law.3. The Assistant Director of Nursing as the Infection Control Coordinator is responsible for the investigation, reporting, control and prevention of infections.		

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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 ensure that the facility maintained a home-like environment for 2 of 2 (Resident # 2, Resident # 63) Residents reviewed for home-like environment. The facility failed to ensure that Resident #2's and Resident #63's bedroom was home-like and free from worn and destroyed walls. This failure could result in psychological distress and feeling uncomfortable in the facility. Findings Included: RR of Resident #2 ?s undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a diagnosis of Type II Diabetes Mellites (chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels), Schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves), and Muscle Weakness. RR of Resident #2's MDS record dated 05/25/2025 revealed the resident had a BIMS score of 15 which indicate no cognitive impairment. RR of Resident #63's undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #63 had a diagnosis of Pseudobulbar Affect (neurological condition characterized by sudden, uncontrollable and often inappropriate episodes of laughing or crying), anxiety disorder and Epilepsy (neurological disorder characterized by recurrent seizures, which are caused by abnormal electrical activity in the brain). RR of Resident #63's MDS record dated 06/26/2025 revealed the resident had a BIMS score of 0 which indicate significant cognitive impairment. An Observation was conducted on 08/06/2025 at 11:35AM of Resident #2's and Resident #63's bedroom. Resident #2's bedroom appeared to be scratched up and torn along the walls next to both Resident #2 and Resident #63's bed. An interview was conducted on 08/07/2025 at 10:55 AM with Resident #2 who stated that his room had been scratched up since before he arrived at the facility. Resident #2 stated that that walls do not make it seem homelike for him. Resident #2 stated that the conditions of his walls and room make him feel like he lives in a facility, rather than a home. An interview was conducted on 08/07/2025 at 2:15PM with CNA A who had worked at the facility for 4 months. CNA A confirmed they received training on homelike environment. CNA A stated homelike environment meant the facility was to try and ensure the resident was comfortable and home-like. CNA A confirmed that the torn-up walls were not homelike for the residents. CNA A stated the MS was responsible for repairs. CNA A stated that staff should notify supervisors when items have been messed up. CNA A stated this could negatively impact residents by them not being comfortable or feel like they aren't at their home. An interview was conducted on 08/07/2025 at 2:35PM with LVN D who had worked at the facility for 1 year. LNV D stated they have received training on homelike environment. LVN D described homelike environment as the facility should make the residents were comfortable in their rooms. LVN D stated MS oversees wall repairs. LVN D stated the facility will notify the MS of any issues or concerns by text message or log it down. LVN D stated this could negatively impact the residents by the potential of increased pressure, anxiety, loneliness and acceptance. An interview was conducted on 08/07/2025 at 2:50PM with MS who had worked at the facility for 3 months. The MS stated he had received training on homelike environment. The MS described homelike environment as the facility should ensure the facility was more like the resident's home and to ensure their quality of life is maintained. The MS stated he oversees repairs. The MS stated this could cause the resident to feel depressed and abandoned. An interview was conducted on 08/07/2025 at 3:10PM with the DON who had worked at the facility since 2020. The DON described the policy for homelike environment as making sure the residents feel like the facility was their current home. The DON stated MS oversees repairs of the facility. The DON stated MS would be notified of the repairs either by text message or maintenance logbook. The DON stated residents could be negatively impacted by feeling anxious. An interview was conducted on 08/07/2025 at 4:00PM with the ADM who had worked at the facility for 2 years. The ADM stated a homelike environment was meant to have residents' belongings in their (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedrooms as well as making the environment comfortable and homelike for them. The ADM stated that MS was responsible for the repairs at the facility. The ADM stated that the MS was aware of repairs by communicating through the maintenance log. The ADM stated this could negatively affect the residents due to the aesthetics, it could make them feel uncomfortable. The ADM stated the conditions of the walls in the bedroom would not be homelike if it wasn't from the resident themselves.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rates are not 5 percent or greater for 1 of 8 residents (Resident #3) reviewed for medication administration. 1. LVN E did not check with order for the parameters on the chart; only on the medication label itself before administering insulin to Resident #3.2. The CMA did not administer two medications (Ferrous Sulfate 325mg 1 tablet every day and Cholecalciferol 25mcg 1 tablet one time a day) to Resident #3. This failure could potentially exacerbate the residents' diagnosis and lead to hospitalization. Findings included: Resident #3 Record review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes mellitus type 2, osteomyelitis (bone infection), acquired absence of left great toe, vascular dementia, hypertension (high blood pressure), cerebral infarction (stroke), and muscle weakness. Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected a BIMS Score of 4, which reflected severe cognitive impairment. The MDS reflected Resident #3 had a diagnosis of diabetes mellitus type 2. Resident #3's MDS further reflected a surgical wound that required surgical wound care, application of ointments/medications, and application of dressings to feet. Record review of Resident #3's Care Plan, last revised on 07/16/25/25, reflected he had a diagnosis of diabetes mellitus. The goal reflected Resident #3 would have no complications related to diabetes through review date of 07/16/25. Interventions included Resident #3 took diabetes medication as ordered by doctor, and to monitor and document for side effects and effectiveness. Review of Physician Orders for Resident #3 reflected: Novolin R injection solution 100 units/mL, inject as per sliding scale: If blood sugar 151-200 - 2 units If blood sugar 201-250 - 4 units If blood sugar 251-300 - 6 units If blood sugar 301-350 - 8 units If blood sugar 351-400 - 10 units If blood sugar 401 + - 12 units and recheck in 15 minutes, subcutaneously before meals and at bedtime for type 2 diabetes mellitus. Observation on 08/06/2025 10:39 AM of blood glucose check for Resident #3 revealed LVN E did not check his order for the parameters on the chart; only on the medication label itself before administering insulin. Observation on 08/06/25 at 11:46 AM, during medication administration observation, CMA A did not administer two medications (Ferrous Sulfate 325mg 1 tablet every day and Cholecalciferol 25mcg 1 tablet one time a day) to Resident #3. Interview on 08/06/25 at 11:52 AM with CMA A revealed he was supposed to give Ferrous Sulfate 325mg 1 tablet every day and Cholecalciferol 25mcg 1 tablet one time a day to Resident #3 and stated that he did not give them this morning because he had forgotten. CMA A stated he documented the medications in the MAR, but did not administer them to Resident #3. Interview on 08/07/25 4:05 PM with the DON who stated the charge nurse, and the DON were responsible for ensuring opened medication bottles and other packages are labeled/dated. He further stated medication should be dated when opened, and unopened insulin should be kept in the refrigerator. He stated over the counter medications OTC bottles such as Mylanta should be dated when opened and disposed of within 30 days. The DON stated when supplements such as Med Pass 2.0 were opened, it should be stored on ice, dated, and discard after one day of use. He further stated if left opened and kept in cart it will go bad and make the residents sick. The DON stated a potential negative outcome to the residents when controlled substances are not signed out, and medications are not labeled with a date when opened was the resident could receive medication at the wrong time and could run out of medication. Record review of the facility's Medication Storage Protocol dated 03/15/18 reflected, Protocol: All medications must be stored in the best possible way for safety both for residents and the facility. 3. Ophthalmic, inhalers, all flushes, multiple dose vials including Insulin, irrigation solution and IV fluids must be marked with date opened or first used. 8. Medication carts must be checked on a monthly basis, or more often, to be sure all medications are in date and have the required dating. Record review of the facility's undated Medication Administration policy and procedure reflected, The facility will ensure (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that medication pass is within the one-hour window and all clients will be given their medication in a safe manner.Procedure: The caregiver trained to give medications will ensure that the seven rights of Medication Administration are followed:a. Right clientb. Right drugc. Right timed. Right dosagee. Right roufef. Right techniqueg. Documentation6. Document all medications administered in their proper MAR.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a call light was accessible while in bed for 1 of 1 (Resident #2) Residents reviewed for call lights. The facility failed to ensure that Resident #2 had a call light next to their bed. This failure could result in a resident not being able to call for help during an emergency. Findings Included: RR of Resident #2 ?s undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a diagnosis of Type II Diabetes Mellites, Schizophrenia, and Muscle Weakness. RR of Resident #2's MDS record dated 05/25/2025 revealed the resident had a BIMS score of 15 which indicate no cognitive impairment. An observation was conducted on 08/05/2025 at 12:30PM in Resident #2's bedroom where a call light was missing from the call light spot located between the two resident's beds. It was observed that Resident #2's roommate had a call light next to their bed, but not for Resident #2. An observation was conducted on 08/06/2025 at 2:15PM in Resident #2's bedroom where a call light was now connected to the call light spot and sitting behind Resident #2's bed. AN interview was conducted on 08/07/2025 at 10:55AM with Resident #2 who stated he has not had his own call button since he arrived at the facility. Resident #2 stated that he doesn't know how he would call for help. Resident #2 stated that he couldn't use the call light and that made him feel like he couldn't ask for help. An interview was conducted on 08/07/2025 at 2:15PM with CNA A who had worked at the facility for 4 months. CNA A stated the importance of call lights was If there was a call light staff must go quickly. CNA A sated if the resident calls it could be because the resident may need something or help. CNA A stated if the resident did not have a call light, staff would know if there was an emergency during rounds. CNA A stated that it was important to ensure that residents had access to call lights. CNA A stated if a resident did not have a call light, it could negatively affect them by not having access to help or the care they need. An interview was conducted on 08/07/2025 at 2:35PM with LVN D who had worked at the facility for 1 year. LVN D stated the importance of call lights was for the safety and necessity of taking care of the patient's needs. LVN D stated the facility would be aware of an emergency during rounds that occur every 2 hours. LVN D stated that not having access to a call light could negatively affect a resident by not having help during an emergency. An interview was conducted on 08/07/2025 at 2:50PM with the MS who had worked at the facility for 3 months. The MS stated the importance of call lights could be life or death, it was so that residents can communicate with staff if they need something or if there was an emergency. The MS stated that residents could yell for staff in case of an emergency. The MS stated not having a call light could negatively affect the residents by the inability to contact staff during an emergency. An interview was conducted on 08/07/2025 at 3:10PM with the DON who had worked at the facility since 2020. The DON stated the importance of call lights was making sure that residents needs were being attended to. The DON stated the residents could possibly scream in case of an emergency if they did not have a call light. The DON stated not having a call light could negatively affect residents by not being able to call for help. An interview was conducted on 08/07/2025 at 4:00PM with the ADM who had worked at the facility for 2 years. The ADM stated the importance of call lights was to serve residents with access to help as needed. The ADM stated if there was an emergency, and the residents didn't have a call light they could yell for help or have a bell to jingle. The ADM stated this could negatively affect the residents by not having assistance when they need help. RR of policy titled Call Lights dated 06/08/2019 reflected the following:1. Residents call lights must be placed within residents' reach.2. All call lights must be checked for condition/functioning.		