STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675459	A. Building B. Wing	02/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Austin	3509 Rogge LN Austin, TX 78723

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person- centered care of the residents that meets professional standards of quality of care within 48 hours of a resident's admission for five (Resident #31, Resident #36, Resident #89, Resident #100, and Resident #139) of ten reviewed for baseline care plans, in that: The facility failed to ensure a baseline care plan was developed for Resident #31, Resident #36, Resident #89, Resident #100, and Resident #139 within 48 hours of admission. This failure could place residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in injury, a decline in physical, mental and/or psychosocial well-being. Findings included: Review of Resident #31's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including end state renal (kidney) disease, hepatic (liver) failure, anxiety disorder, and dependance on renal dialysis. Review of Resident #31's baseline care plan reflected it was completed on 1/19/22. Review of Resident #36's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, CHF, cognitive communication deficit, and presence of cardiac pacemaker. Review of Resident #36's baseline care plan reflected it was completed on 2/1/22. Review of Resident #89's undated face sheet reflected a [AGE] year-old male who was initially admitted on [DATE] and re admitted on [DATE] with diagnoses including cerebral infarction (stroke), COVID-19, Acute respiratory failure, sepsis (infection), type 2 diabetes, anxiety disorder, and heart failure. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #89's baseline care plan for the 2/1/22 admission reflected his primary language was English, his code status was DNR, and he was allergic to tetracycline. There were no other entries on the care plan, and it was not dated or signed. Review of Resident #100's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, pneumonitis, and pneumonia due to COVID-19. Review of Resident #100's EMR reflected no care plan. Review of Resident #139's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis of liver with ascites, hepatic failure (liver), COVID-19, COPD, anemia (low blood iron), kidney failure, and generalized muscle weakness. Review of Resident #139's EMR from 1/21/22 through 2/9/22 reflected no baseline care plan. During an interview on 2/11/22 at 1:20 PM with LVN G, she stated She does not do care plans because she was an LVN. She stated the DON or RN supervisor on the weekends was responsible for the care plans. During an interview on 2/12/22 at 9:42 AM with LVN H, she stated she does not initiate, update, or revise care plans. She stated the DON was responsible for care plans. During an interview on 2/11/22 at 10:03 AM with the QAS, she stated she works at a sister facility and was responsible for care plans. She stated she was coming to the facility weekly to help straighten up the care plans. She stated baseline care plans should be completed within 48 hours. She stated a negative outcome of them not being completed timely and accurately would be that staff would not be aware of what to monitor or identify with the resident. She stated this could result in residents not being properly cared for. During an interview on 2/13/22 at 11:29 AM with the ON and the Owner, the DON stated baseline care plans should be completed within 48 hours. He stated the MDS Nurse was responsible for ensuring they are completed within the timeframe. He stated their current MDS Nurse was part-time and works remotely. He stated he was not sure why the baseline care plans were not being completed in time. He stated it was his responsibility to ensure they were completed within the timeframe. Review of the facility's undated Care Plan Policy reflected the following: . 9. Upon admission a baseline care plan should be initiated within the first 48 hours. It can be filled out by an LVN or RN and reviewed by an RN.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for three (Resident #8, Resident #17, and Resident #22) of six residents reviewed for showers, in that: The facility failed to provide showers to Resident #8, Resident #17, and Resident #22 in compliance with their shower schedules. This deficient practice could place residents at risk of a decline in their sense of well-being, level of satisfaction with life, and at risk for skin breakdown. Findings included: Review of Resident #8's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, adult failure to thrive, and cerebral infarction. Review of Resident #8's MDS, dated [DATE], reflected she was totally dependent for showers. Review of Resident #8's care plan, revised 2/8/22, reflected she had an ADL self-care performance deficit related to impaired cognition and impaired mobility with an intervention of being totally dependent on one staff for showers. Review of Resident #8's bathing tasks in her EMR, from 1/10/22 - 2/10/22, reflected she received two showers during that time frame where only Supervision was needed, on 1/17/22 and 2/7/22. Review of the facility's shower sheets binder reflected Resident #8 received a shower on 1/12/22. Observation on 2/8/22 at 8:04 AM revealed Resident #8 in her bed with her eyes closed. Her face was greasy and there was a strong urine odor. Review of Resident #17's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure, contractures, anoxic brain damage, and unspecified severe protein-calorie malnutrition. Review of Resident #17's MDS, dated [DATE], reflected he was totally dependent for showers. Review of Resident #17's care plan, revised 2/8/22, reflected he had an ADL self-care performance related to anoxic brain injury, requiring total care for all ADLs and mobility. Review of Resident #17's bathing tasks in his EMR, from 1/10/22 - 2/10/22, reflected he received two showers during that time frame, on 1/26/22 and 2/2/22. Review of the facility's shower sheets binder reflected Resident #17 received a shower on 1/20/22. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/8/22 at 8:43 AM revealed Resident #17 in his bed with his eyes closed. His lips were dry, and his hair and skin were greasy. During an interview on 2/9/22 at 9:41 AM with Resident #17's RP, she stated she had a camera in his room and never sees the staff tend to him. She stated he smelled because he's not receiving baths. She stated when she visited him, she always asks for assistance washing his hair because it was so greasy, but they never helped her. Review of Resident #22's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including idiopathic progressive neuropathy, chronic viral hepatitis C, generalized anxiety disorder, and other abnormalities of gait and mobility. Review of Resident #22's care plan, revised 8/9/21, reflected he had an ADL self-care performance deficit related to impaired cognition and impaired mobility with an intervention of requiring physical assistance with bathing/showering and to provide showers/bathing per schedule and PRN. Review of Resident #22's MDS, dated [DATE], reflected he required supervision with showers. Review of Resident #22's bathing tasks in her EMR, from 1/10/22 - 2/10/22, reflected he received two showers during that time frame, on 1/20/22 and 1/27/22. Review of the facility's shower sheets binder reflected Resident #22 received a shower on 1/12/22. During an interview on 2/9/22 at 10:14 AM with Resident #22, he stated he rarely received showers. He stated it had been at least two weeks since he received his last shower. He stated he hated feeling dirty. He stated if he asked for a shower, the staff would tell him they were too busy. During an interview on 2/9/22 at 8:52 with LVN G, she stated the aides document showers using both PCC and shower sheets. She stated the shower sheets should match what was in PCC. During an interview on 2/11/22 at 9:07 AM with CNA A, she stated she documented showers on shower sheets. She stated if a resident refused, she would try again five minutes later. She stated if they refused again, she would document the refusal. During an interview on 2/13/22 at 11:43 AM with CNA B, she stated she showered residents on their shower days. She stated she documented the showers on the shower sheets. During an interview on 2/11/22 at 10:20 AM with the ADM, he stated his expectations on showers were that they occurred per the residents' shower schedule and PRN. He stated a negative outcome of not receiving regular showers, besides being dirty, was it could cause infection. He stated showers tied in with their care and was part of their well-being. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/22 at 11:29 AM with the DON, he stated his expectations were that the aides showered the residents according to their shower schedules. He stated the aides should be documenting if there was anything unusual on the skin and should notify the nurse. He stated if a resident continued to refuse a shower, the aides should also notify the nurse. A negative outcome of not receiving showers regularly could be foul hygiene, fungal infections, not assessing skin, and unidentified wounds. He stated he believed the facility should stop using the shower sheets and only use PCC in order to track the showers more efficiently. Review of Resident Council Minutes, dated 11/29/21, reflected the residents had concerns about not receiving showers on their scheduled days or not at all. During an interview with the DON on 2/10/22 at 11:00 AM a request for a policy on providing showers but was not provided prior to exit.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for four (Resident #8, Resident #17, Resident #18, and Resident #89) of eight residents reviewed for pressure wounds, in that: The facility failed to: A.) consistently complete weekly wound and skin care assessments for Resident #8 and Resident #17. B.) obtain wound care orders from a physician when Resident #8 acquired a new sacral wound. C.) identify Resident #18's sacral wound until a prompted skin sweep was conducted. D.) identify a pressure injury on Resident #89 during a skin sweep. These failures affected residents with pressure ulcers, and could result in improper wound management, the development of new pressure ulcers, deterioration in existing pressure ulcers, infection, and pain. Findings included: A.) Review of Resident #8's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, adult failure to thrive, and cerebral infarction (stroke). Review of Resident #8's MDS, dated [DATE], reflected she had a pressure ulcer to her right heel. Review of Resident #8's care plan, revised 2/8/22, reflected she was at risk of skin breakdown related to incontinence with interventions of observing skin weekly per schedule and report any open/red areas, and to notify the MD and wound care nurse as appropriate and implement ordered interventions. Review of Resident #8's assessments reflected a weekly wound or skin assessment was completed on 1/24/22, and then not again until 2/8/22. Review of Resident #8's weekly wound assessment, dated 1/24/22, reflected an unstageable pressure injury to her right heel, measuring 3.2 cm x 4.5 cm. A weekly wound or skin assessment was not conducted again until 2/8/22, in which she had acquired a stage III pressure injury to her sacram. Review of Resident #8's weekly wound assessment, dated 2/8/22, reflected an unstageable pressure injury to her right heel, measuring 3 cm x 4.5 cm and a stage III pressure injury to her sacrum, measuring 1 cm x 3. 5 cm x .3 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #17's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure, contractures, anoxic brain damage, and unspecified severe protein-calorie malnutrition. Review of Resident #17's MDS, dated [DATE], reflected he had an unspecified wound to his right thumb. Review of Resident #17's care plan, revised 2/8/22, reflected he was at risk of skin breakdown related to incontinence with interventions of observing skin weekly per schedule and report any open/red areas, and to notify the MD and wound care nurse as appropriate and implement ordered interventions. Review of Resident #17's assessments reflected a weekly wound assessment was completed on 1/4/22 for his stage IV pressure injury to his right thumb, and then not again until 2/8/22. Review of Resident #17's weekly wound assessment, dated 1/4/22, reflectted a state IV pressure injury to his right thumb, measuring .4 cm x .2 cm x .5 cm. Review of Resident #17's weekly wound assessment, dated 2/8/22, reflected a stage IV pressure injury to his right thumb, measuring .3 cm x .2 cm x .1 cm. B.) Review of Resident #8's weekly wound assessment, dated 1/24/22, reflected an unstageable pressure injury to her right heel, measuring 3.2 cm x 4.5 cm. Review of Resident #8's assessments, reflected there was no weekly skin or wound assessment completed from 1/24/22 and 2/8/22. Review of Resident #8's weekly wound assessment, dated 2/8/22, reflected an unstageable pressure injury to her right heel, measuring 3 cm x 4.5 cm and a stage III pressure injury to her sacrum, measuring 1 cm x 3. 5 cm x .3 cm. Review of Resident #8's wound care doctor's notes reflected she had been treating a wound on her sacrum weekly since 1/31/22. Review of Resident #8's wound care doctor's note, dated 1/31/22, reflected a stage II sacral wound, measuring 1 cm x 3 cm x .1 cm. Review of Resident #8's wound care doctor's note, dated 2/7/22, reflected her sacral wound had progressed from a stage II to a stage III, measuring 1 cm x 3.5 cm x .3 cm. Review of Resident #8's TAR for February 2022, reflected a physician's order for her sacral wound was not entered until 2/8/22. Review of Resident #8's physician order, dated 2/8/22, reflected to clean her sacrum with wound cleanser, mix collagen powder with barrier cream, and apply to wound TID three times a day for wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/9/22 at 12:28 PM with Resident #8's NP, he stated he had not been made aware of her sacral wound. He stated he expected to be notified of all wounds acquired by the residents. He stated a resident had a wound, there should be physician treatment orders in their EMR. During an interview on 2/9/22 at 12:42 PM with the Owner, DON, and ADON, the ADON stated she was aware of Resident #8's sacral wound and had been treating it with barrier cream. The Surveyor reminded her that there was no documentation of any treatment occurring nor had there been any physician orders for treatment of the wound in her EMR, and the wound had worsened from a stage II to a stage III. The Owner stated they were going to complete a skin sweep and assess every resident in the facility for any skin issues. During an interview on 2/9/22 at 3:15 PM with the DON, he stated the skin sweep had been completed and there had been no additional skin issues found. C.) Review of Resident #18's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including COPD, vascular dementia, unspecified atrial fibrillation, and nontraumatic intracerebral hemorrhage. Review of Resident #18's MDS, dated [DATE], reflected no documentation of any skin issues. Review of Resident #18's care plan, revised 7/23/2, reflected she was at risk for skin breakdown related to impaired mobility with interventions of observing skin weekly per schedule and report any open/red areas, and to notify the MD and wound care nurse as appropriate and implement ordered interventions. Review of Resident #18's weekly wound assessment reflected no skin issues. There was no weekly skin or wound assessment completed until the prompted skin sweep on 2/9/22. Review of Resident #18's weekly wound assessment, dated 2/9/22, reflected a stage II pressure injury to her left buttock, measuring .3 cm x .4 cm x .1 cm. D.) Review of Resident #89's undated face sheet reflected a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction, COVID-19, Acute respiratory failure, sepsis, type 2 diabetes, anxiety disorder, and heart failure. Review of Resident #89's MDS, dated [DATE], reflected no pressure ulcers/injuries. Review of Resident #89's baseline care plan for the 2/1/22 admission reflected his primary language was English, his code status was DNR, and he was allergic to tetracycline. There were no other entries on the care plan including skin status or skin risks. Further review of the medical record reflected a comprehensive care plan had not been initiated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 2/10/22 at 8:84 AM revealed Resident #89 making frequent position changes while lying in bed, yelling out, and coughing. Resident's feet were hitting the footboard and a one-to-two-centimeter pressure injury was noted on the lateral aspect of his right heel. The area was non-blanchable and red. The center was darker red with some skin missing. The wound was consistent with a stage II pressure injury. During an interview on 2/10/22 at 9:00 AM, the ADON stated she had seen Resident #89 at the start of the shift and had administered medications to him but did not notice pressure injury on his foot. Review of the skin assessment for Resident #89 completed on 2/9/22 by the corporate nurse revealed no skin issues or pressure injuries. During a phone interview on 2/10/22 at 10:52 AM with the corporate nurse(CNA C), she stated she was a Travel CNA not a nurse. She stated she had been a CNA for over [AGE] years. She stated that the owner had asked her to help with the skin sweeps. She and another CNA checked the residents and wrote down what they saw. She stated she initiated all the skin sheets by writing the resident names on the form in blue ink. She stated the ADON volunteered to write down the concerns she already knew about to help save time. She stated the black ink on the forms was from the ADON. She stated she has not had any training on completing skin assessments. She stated if she found a skin issue during the course of her work, she would tell the charge nurse and the ADON. During an interview on 2/10/22 at 10:56 AM with the NP, he stated an aide should not be completing wound assessments. He stated only either an RN or LVN should be completing them. He stated it was unacceptable that the pressure injury on Resident #89 was not found during the skin sweep. The Wound Care Doctor was called on 2/10/22 at 2:34 PM; a message was left requesting a call back. Review of the facility's undated Wound Care Policy reflected the following: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure. Review of the facility's Risk and Skin Assessment Policy, dated 4/21, reflected the following: Purpose: The purpose of this policy is to establish a consistent and objective method of assessing the resident's risk for wound and pressure injury development and to implement a standardized plan to prevent wounds and pressure injury as much as possible. . Procedure: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	. II. All residents will have a visual inspection of their skin A. A completed head-to-toe skin check is competed by the licensed nurse as soon as possible after admission. B. Skin checks are completed weekly and as needed by the licensed nurse and are documented in the medical record. C. Skin/body check is completed on each shower day by nursing assistant staff. The ADM and DON were notified on 2/10/22 at 3:45 PM that an Immediate Jeopardy situation had been identified due to the above failures. The IJ template was provided to the Administrator on 2/10/22 at 3:45 PM. A Plan of Removal was first submitted by the Owner on 2/10/22 at 5:30 PM and the following POR was accepted on 2/12/22 at 4:28 PM: On 2.09.22 Surveyors found a patient had a sacral wound with no treatment order. Weekly skin assessment for that patient were not done on a weekly basis. The Attending Physician was not aware of the sacral wound. Surveyors then found a pressure ulcer on another patient's right heel. Patients who are at risk of acquiring pressure ulcers are at risk of this alleged deficiency. Patients who are at risk of acquiring pressure ulcers are at risk of this alleged deficiency. These will be identified with a Braden scale. There are currently 12 patients with skin concerns For the patients affected, a new skin assessment was done on 2.10.22 by licensed nurses. Wound assessments are being done on 2.11.22 by ADON or designee (Licensed Personnel). MD notification is being done by ADON or designee on 2.11.22. Treatment orders from MD are being put in by ADON or designee on 2.11.22. On 2.9.22 and 2.10.22 the facility did a skin sweep to identify any concern with skin conditions with Licensed Nurses leading the sweep. Any skin condition identified will be notified to the doctor by a nurse and a treatment order will be put in if the doctor orders it. Patients at risk are identified by Braden score. A Braden audit is being done by Nurse consultant and at-risk patients are identified and given to DON. Problem 1: -Review of the Wound Doctor's notes reflected R2 had acquired a stage II sacral wound on 1/31/22 and she (Wound Doctor) was assessing her wounds weekly (she also has a PU on her right heel). Her last assessment was completed on 2/7/22, indicating the sacral wound had progressed to a stage III. The facility's skin assessment for R2, completed 1/24/22, reflected a pressure ulcer to her right heel. There was not another one completed until 2/8/22, where the sacral wound was assessed. There were no wound care orders until 2/8/22. The ADON stated she was aware of the wound and had been applying barrier cream. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Action Taken: Physician called for order for patient R2 with skin concerns and put in the medical record By ADON 2.08.22. Monitoring: DON or ADON will verify that patients with skin concerns have physician treatment orders, the monitoring will be done 5x a week Monday to Friday to verify that patients with skin concerns have treatment orders in the medical record for 12 weeks. These findings will be monitored on a Quality Assurance Document to be reviewed weekly on Wednesday by DON or Corporate Nurse for 12 weeks The Physician and IDT will be notified of new and worsening pressure wounds, complaints of pain, signs and symptoms of infection or sepsis and residents who refuse care or treatment. Findings and updates will be reported to the Administrator or Designee and reported to the QA Meetings as part of the QA Process. Problem 2: Review of the skin assessments done when surveyor mentioned a concern for R2. on 2/10/22 reflected an additional resident, R3, having a stage II pressure ulcer on her left buttock. Action Taken: Re-education to licensed staff of the need for the skin checks to be done weekly by DON on 2. 11.22. Skills checkoffs done by DON to Licensed Personnel for Skin assessments on 2.11.22. CNAs were re-educated regarding notifying Licensed nurse and management of a change in skin condition. A reward system for CNAs to notify Nurse Management of new skin issues is put into place on 2.11.22 by DON. Monitoring: DON is utilizing a quality assurance document to ensure that weekly skin checks are being done, being done accurately. This was started on 2.10.22 by DON to be done 5x a week Monday to Friday to verify that patient's skin are being checked weekly. DON is also to spot check a skin check once a week to verify accuracy of the assessment. Findings and updates will be reported to the Administrator or Designee and reported to the QA Meetings as part of the QA Process. Problem 3: Additionally, the Surveyors located a pressure ulcer on R4's right heel on 2/10/22 at 8:20 AM. R4's skin assessment from the day prior reflected no skin issues. Action Taken: DON and ADON did a second skin sweep of the patients in the building on 2.10.22. Re-education to licensed staff of the need for the skin checks to be done accurately weekly by DON on 2.11. 22. Skills checkoffs done by DON to Licensed Personnel for Skin assessments on 2.11.22. CNAs were re-educated regarding notifying Licensed nurse and management of a change in skin condition. A reward system for CNAs to notify Nurse Management of new skin issues is put into place on 2.11.22 by DON. Monitoring: DON is utilizing a quality assurance document to ensure that weekly skin checks are being done, being done accurately. This was started on 2.10.22 by DON to be done 5x a week Monday to Friday to verify that patient's skin are being checked weekly. DON is also to spot check a skin check once a week to verify accuracy of the assessment. Findings and updates will be reported to the Administrator or Designee and reported to the QA Meetings as part of the QA Process. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The survey team monitored the plan of removal on 2/13/22 as follows: During an interview on 2/13/22 at 10:00 AM with RN I, she stated she and all of the nurses had been in-serviced the previous Friday, 2/11/22, on completing weekly skin checks on all residents because they were responsible for the integrity of the residents' skin. She stated they were also in-serviced on reviewing shower sheets daily to hold the aides accountable and to ensure they were being thorough. She stated it was not just up to the aides, as they were all part of the residents' care team. She stated not doing these things could compromise the health of the resident or lead to infection and further neglect. She stated they need to come up with interventions. For example, if an aide noticed redness to a resident's bottom, she would ask the aides to reposition the resident more often to ensure it did not get worse. She stated they also needed ensure they are notifying the MD if there were any new skin issues. During an interview on 2/13/22 at 10:40 AM, he stated all nurses and aides were in-serviced on pressure ulcer assessments, prevention of pressure ulcers, and weekly skin assessments. He stated all nurses received competency checks on skin assessments and identifying residents at risk of developing pressure injuries or worsening of existing pressure injuries. He stated all residents had a skin assessment by the ADON and himself, with no new skin issues. During an interview on 2/13/22 at 11:43 AM with CNA B, she stated she had been in-serviced on looking for open areas and redness on residents while performing care. She stated when identifying a new skin issue, it was important to notify the nurse immediately so they could do a further assessment. During an interview on 2/13/22 at 11:52 AM with CNA E, she stated she was in-serviced on assessing the residents' skin during care for redness, bruising, skin tears, open areas, and to even check the status of their toenails. She stated if they find any skin issues, they are to report it to the nurse immediately and document the issue in the resident's chart. During an interview on 2/13/22 atn12:18 PM with LVN F, she stated all nursing staff were in-serviced on being thorough during skin assessments. The nurses were responsible for completing them weekly. They would be assigned a hall to complete skin assessments on and will also document the assessment in the residents' EMR. The aides will be notifying them if they see any changes in a resident's skin. Review of all of the residents' EMR reflected they had a completed Braden Scale Assessment as well as an updated full-body skin assessment. All residents with pressure injuries had up-to-date treatment orders. Review of the Competency Assessment given to all nurses on 2/11/22 reflected a Pressure Injury Risk Assessment with the purpose of providing guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of exiting pressure ulcers. Review of an in-service provided by the DON on 2/10/22 reflected the following: Topic(s): Weekly skin assessments and wounds (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. On admission/re-admission a complete skin assessment must be completed, any skin deviations must be documented immediately in PCC. Physician must be notified immediately of any skin integrity that is not intact to receive orders. 2. Weekly skin assessments must be completed every week by the nurse. Each nurse will be assigned a hall/halls to complete skin assessments on to meet documentation guidelines, assigned weekly skin assessments must be entered into PCC before the end of the working shift. 3. If a wound or skin deviation is noted an order must be entered into PCC, a Braden scale must be completed along with a pain assessment and a nursing note. If it is a wound an additional wound sheet must be completed in PCC with measurements. 4. CNA's will report skin uses to the nurse immediately if any skin issues are noted during showers or during peri-care. 5. Any wound requires the physician, family, DON and ADON to be notified immediately. When in doubt, report! Review of an in-service provided by the DON on 2/11/22 reflected the following: Topic(s): Giving patients showers, weekly skin check, PCC - no shower binder, shower refusals 1. Shower expectations are that every patient is shower at minimum 3x a week and PRN. 5. Any new skin conditions, pressure or non-pressure (rash) must be notified to: a. DON b. Administrator c. MD - Treatment orders must be put in on that shift per MD guidance. On 2/13/2022 at 12:30 PM the administrator was notified the IJ was removed . The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not IJ and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review the facility failed to ensure that pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #8, Resident #17, and Resident #33) of ten residents reviewed for pain, in that: The facility failed to: A.) Provide interventions for Resident #17 when he grimaced and clenched his fists tighter during wound and trach care. B.) Assess Resident #8 Resident #17's pain, who were nonverbal, with an appropriate pain scale and every shift as ordered. C.) Ensure staff were assessing pain for Resident #33 who was able to express her pain level. These failures could place residents at risk for prolonged and unnecessary pain and suffering, decreased mobility, decreased quality of life, and decreased quality of care. Findings included: A.) Review of Resident #17's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure, contractures, anoxic brain damage, and unspecified severe protein-calorie malnutrition. Review of Resident #17's MDS, Section C, dated 1/14/22, reflected a BIMS of 0, indicating a severe cognitive impairment. Review of Resident #17's MDS, Section B, dated 1/14/22, reflected he had no speech, was rarely/never understood, and rarely/never understands others. Review of Resident #17's care plan, revised 2/8/22, reflected he was at risk for pain due to contractures, infections, trach, tunneled cath placement, and GI scarring with interventions of observing him for non-verbal signs and symptoms of pain to include but not limited to: facial grimacing, guarding restlessness, agitation. Review of Resident #17's MDS, dated [DATE], reflected in the last five days he did not received scheduled pain medication, did not receive PRN pain medications or was offered and declined, or received non-medication intervention for pain. Additionally, it reflected a pain assessment interview should be conducted, but under the interview questions, Unable to answer is marked. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/8/21 at 12:03 PM, the ADON entered Resident #17's room, performed hand hygiene, and donned clean glove. The overbed table was already set up with the supplies she needed to perform trach care. The ADON touched the resident's shoulder lightly and explained the procedure in English. Resident #17 flinched when she touched his shoulder. The ADON proceeded to remove the inner canula from the trach and clean the trach and skin. Resident #17 clinched his contracted hands tight and drew his arms closer to his body. He moved his head so that his chin was closer to his chest and he squinted his eyes tightly. The ADON told the surveyor previously when she performed wound care on the resident her hand got stuck between the resident's arm and his body because he clinched his arm so tightly. She stated she had to just stand there and wait for him and his muscles to relax before she could get her hand free. After completing trach care, the ADON cleaned up and prepared for wound care. The ADON cleaned the wound on the resident's thumb and applied a new dressing. The resident's hands and eyes remained tightly clenched. The ADON stated the resident reacts that way (grimaces, flinching, and contracting his muscles) all the time. Stated they tried pain medication in the past, but nothing ever worked. The ADON did not ask resident about pain during the observation of trach and wound care. As reflected in the review of Resident #17's pain assessments, there is no documentation of pain prior to trach and wound care. During an interview on 2/8/22 at 3:20 PM with RN J, she stated she had assessed Resident #17 for pain on 2/7/22 using the PAINAD scale and determined his pain to be at a level 8 and thus she administered pain medication. She stated the medication was effective because when she went back to reassess him, his face and body were more relaxed, and he was not grimacing. She stated it would not be appropriate to use a numeric pain scale to assess his pain as he is not able to communicate verbally. During an observation and interview on 2/9/22 at 8:47 AM with Resident #17, the Surveyors repeatedly stated, Dolor?, which is pain in Spanish, his primary language. Resident #17 would squint his eyes, moan lightly, and nod his head yes. During an interview on 2/9/22 at 9:41 AM with Resident #17's RP, she stated he was always grimacing and did have his fists clenched due to hand contractures. She stated he does grimace harder and clench his fists harder when any kind of care is provided. She stated she believed it hurt him and he was trying to express it. She stated he would not be able to tell someone if he was in pain or answer to a numerical pain scale. During an interview on 2/9/22 at 12:28 PM with Resident #17's NP, he stated there was no way staff should be using a numerical pain scale for Resident #17. He stated no unresponsive residents should be assessed for pain using a numerical pain scale. He stated if Resident #17 had been showing signs of pain during wound or trach care, the staff should have notified him so he could have prescribed medication to be given prior to wound or trach care. During an interview on 2/9/22 at 1:32 PM with the Owner, DON and ADON, the ADON stated Resident #17 was always grimacing. The ADON stated in the past they tried everything including pain medication, anxiety medication, and muscle relaxers, and nothing had worked. The DON stated that Resident #17 tensed up regardless of what care was being provided. He stated if he went in his room and just touched him, he would tense up. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/22 at 10:00 AM with RN I, she stated Resident #17 did understand what was going on. She stated when his son visits and lets Resident #17 know he was about to leave, Resident #17 would start crying. She stated she had not performed any kind of are on him in a while but did know he showed signs of pain during care. She stated they used to have orders to medicate before treatment or care in the past but was not sure if the orders were still there. B.) Review of Resident #17's physician order, dated 10/17/21, reflected to assess him for pain every shift. Review of Resident #17's pain assessments from 2/1/22 - 2/8/22 reflected the following: Date Value Scale 2/1/22 1:00 AM 0 Numerical 2/1/22 2:47 AM 7 Numerical 2/1/22 4:41 AM 0 Numerical 2/3/22 3:38 AM 0 Numerical 2/4/22 2:42 AM 0 PAINAD 2/4/22 9:05 AM 0 Numerical 2/4/22 2:33 PM 0 PAINAD 2/5/22 2:15 AM 8 PAINAD 2/5/22 10:45 AM 0 Numerical 2/5/22 9:32 PM 0 Numerical 2/5/22 11:59 PM 0 Numerical 2/6/22 10:09 AM 0 Numerical 2/6/22 5:31 PM 0 Numerical 2/7/22 1:30 AM 0 Numerical 2/7/22 8:39 PM 8 PAINAD 2/7/22 2:13 PM 0 PAINAD 2/8/22 5:59 AM 0 Numerical (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/8/22 12:57 PM 0 Numerical Review of Resident #8's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, adult failure to thrive, cognitive communication deficit, and cerebral infarction. Review of Resident #8's MDS, Section C, dated 1/5/22, reflected a BIMS of 0, indicating a severe cognitive impairment. Review of Resident #8's MDS, Section B, dated 1/5/22, reflected she had continuous disorganized or incoherent conversation. Review of Resident #8's MDS, Section J, dated 1/5/22, reflected she was unable to answer the question of Have you had any pain or hurting at any time in the last 5 days? Review of Resident #8's pain assessments from 2/1/22 - 2/8/22 reflected the following: Date Value Scale 2/1/22 1:07 AM 0 Numerical 2/1/22 3:11 AM 0 Numerical 2/2/22 5:12 AM 0 Numerical 2/3/22 6:03 AM 0 Numerical 2/3/22 10:42 AM 2 Numerical 2/4/22 2:46 AM 0 PAINAD 2/4/22 3:44 AM 0 PAINAD 2/5/22 2:00 AM 0 Numerical 2/5/22 11:51 PM 0 Numerical 2/6/22 4:40 AM 0 Numerical 2/7/22 1:21 AM 0 Numerical 2/7/22 4:30 AM 0 Numerical 2/7/22 12:01 PM 0 Numerical 2/8/22 3:37 AM 0 Numerical 2/8/22 4:06 AM 0 Numerical (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/8/22 9:39 AM 4 PAINAD 2/8/22 12:50 PM 0 PAINAD During an observation and interview on 2/9/22 at 8:55 AM, Resident #8 was heard screaming from her room. LVN G stated Resident #8 tended to scream during any kind of care being provided. She stated she was not sure if she was yelling in pain. During and observation an interview on 2/9/22 at 8:58 AM, the ST was working with Resident #8 in her room. She stated when she went to assist her with sitting up, she started screaming. She stated she then asked the nurse for pain medication because it was clear she was in pain. The ST stated Resident #8 did not really communicate using words, but she worked with her on swallowing to ensure she would not aspirate. C.) Review of Resident #33's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, COPD, contractures of hands and legs, and type II diabetes. Review of Resident #33's MDS, Section C, dated 1/24/22, reflected a BIMS of 12, indicating no cognitive impairment. Review of Resident #33's MDS, Section J, dated 1/24/22, reflected she was in frequent pain. Review of Resident #33's care plan, revised 2/8/21, reflected she had chronic pain related to diabetic neuropathy, pain disorder related to psychological factors, and osteoarthrosis with an intervention to monitor/record pain every shift and PRN. Review of Resident #33's physician's order, dated 11/20/20, reflected to give 2 tablets of Tylenol 325 MG by mouth every 6 hours as needed for pain. Review of Resident #33's MAR dated 2/1/22 - 2/8/22, reflected her pain level was not assessed, nor was she administered Tylenol for pain. During an interview on 2/9/22 at 9:02 AM with Resident #33, she stated she was always in immense pain due to her contracted fingers and nerve damage to her toes. She stated she was never asked if she was in pain. She stated if she requested pain medication, she never received it, so she just gave up on asking for it. During an interview on 2/10/22 at 8:20 AM with Resident #33, she stated her hands and toes were in so much pain. She stated no one had asked her if she was in pain that morning. During an interview on 2/13/22 at 10:00 AM with RN I, she stated nurses performed pain assessments. She stated it was important to try and find out where the pain was coming from and to notify the MD if there were any new issues. She stated if the resident was non-verbal, a PAINAD scale should be used which used indicators such as facial grimacing, moaning, and body language. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/22 at 11:28 AM with the DON, he stated his expectations were that residents were assessed for pain every shift. He stated non-verbal residents should be assessed for pain using the PAINAD scale, which used moaning, grimacing, and body language as indicators. He stated an adverse outcome of not assessing pain appropriately could be that residents could be in undue pain depending on the process. He stated an adverse outcome of not providing pain management interventions would be that residents would continue to be in pain. Review of the facility's undated Pain Management Policy reflected the following: Purpose: The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines: 1. The pain management program is based on a facility-wide commitment to resident comfort. . 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater when the facility had a medication error rate of 8% based on three (3) errors of 36 opportunities, which involved two (2) (Resident #33 and Resident #90) out of four (4) residents and one (1) LVN (LVN G) observed during medication administration, in that: The facility failed to: A) ensure Resident #33 had a physician order for Cetirizine HCl Tablet (for allergies) with a specific dosage. B) ensure Resident #90 had a physician order for Sennosides Tablet (for constipation) with a specific dosage and ensure one of his medications (Tamsulosin for the prostate) was not crushed. These failures affected two residents and placed other residents at risk for not receiving the correct medications and not receiving their medications as ordered by the physician which could result in adverse drug reactions or ineffective disease management. Findings included: A) Review of Resident #33's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia (lack of oxygen), COPD (lung disease), contractures (deformed/rigid joints) of hands and legs, and type II diabetes. Review of Resident #33's MDS, Section C, dated 1/24/22, reflected a BIMS of 12, indicating no cognitive impairment. Review of Resident #33's physician order dated 11/12/20 reflected, Cetirizine HCl Tablet give 1 tablet by mouth one time a day for allergies. There was no dosage specified. Observation on 2/9/22 at 9:24 AM revealed LVN G prepare Resident #33's medication for administration. She took a bottle of Cetirizine HCl 5 mg from the drawer and put one tablet into the medication cup. She prepared the rest of the oral medications and administered them to Resident #33. During an interview and record review on 2/12/22 at 11:55 AM with LVN G, she stated she gave the dose of Cetirizine that was in the bottle in the medication cart. She stated if she saw a physician's order for a medication without a dose specified, she would call the NP to get clarification on the order. After reviewing the order, she realized that the dose was missing. She stated that not having a dose specified in the order, the resident could get the wrong dose which could cause under- or over-dose and not work as intended. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/22 at 11:53 with the Pharmacy Consultant, she stated Cetirizine comes in 5 MG and 10 MG doses. She stated the physician's order should specify the dose that should be administered. She stated she was surprised the dose was not specified because it auto-populates when the order is being put into the computer. During an interview on 2/13/22 at 11:28 AM, the DON stated his expectations were that physician orders contained the right dose, the right medication, the right route, and the right time. He stated it was the nurse's responsibility to ensure the order contained all of the rights and call the provider for clarification if needed. B) Review of Resident #90's undated face sheet reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included COVID-19, fracture of left femur (leg), abnormal weight loss, anemia (low blood iron), benign prostatic hyperplasia)enlarged prostate gland), chronic kidney disease, acute prostatitis, dysphagia (difficulty swallowing), and metabolic encephalopathy (brain disorder). The face sheet also reflects Special Instructions: CRUSH MEDICATIONS. Review of Resident #90's MDS section C dated 1/14/22 reflected a BIMS of 8, indicating moderate cognitive impairment. Review of Resident #90's care plan, revised 2/8/22, reflected no documentation of difficulty swallowing medications or crushing medications. Review of Resident #90's physician order dated 1/24/22 reflected, Tamsulosin HCl Capsule 0.4 MG give 1 capsule by mouth one time a day for benign prostatic hyperplasia. Review of Resident #90's physician order dated 1/24/22 reflected, Sennosides Tablet give 1 tablet by mouth two times a day for constipation. There was no dose specified in the order. Observation of med pass on 2/9/22 at 9:14 AM revealed LVN G preparing medications for administration to Resident #90. She poured Apixaban, Metoprolol, Vitamin D3, Sennosides 8.6 MG into a med cup then proceeded to crush the medications. She mixed all the medications together in the medicine cup with some applesauce. She then opened the Tamsulosin 0.4m MG capsule and poured that on the applesauce mixture. She administered the medications to the resident. During an interview on 2/10/22 at 11:53 with the Pharmacy Consultant, she stated Tamsulosin should not be opened. She then stated, But if they have been doing it for a long time, it must be okay. She stated crushing or opening medications that should not be crushed or opened could cause unwanted side effects. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675459	A. Building B. Wing	02/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Austin	3509 Rogge LN Austin, TX 78723

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/22 at 11:55 AM with LVN G, she stated she gave the dose of Sennoside that was in the bottle in the medication cart. She stated if she saw a physician's order for a medication without a dose specified, she would call the NP to get clarification on the order. After reviewing the order, she realized that the dose was missing. She stated that not having a dose specified in the order, the resident could get the wrong dose which could cause under- or over-dose and not work as intended. She stated if a medication is not supposed to be crushed, there would usually be a sticker on the card that says, Do Not Crush. She thought there may be a list of medications not to crush posted in a medication room. She checked the binder on the nearest med cart but was not able to find a list there. During an interview on 2/13/22 at 11:28 AM, the DON stated an adverse outcome of crushing a medication that should not be crushed could be absorbing more of the medication than intended and possibly causing an overdose. Review of the facility's undated Medication Administration policy reflected in part . 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The policy did not address crushing medications.