STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675118	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Country Nursing and Rehabilitation	6500 Brush Country Rd Austin, TX 78749

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on interview and record review, the facility failed to ensure all residents were discharged per facility requirements for one (Resident #1) of 8 residents reviewed for discharge requirements. The facility failed to complete and document in Resident #1's chart her discharge planning and summary upon her discharge on 4/12/2024. This failure placed residents at risk of improper discharges. Findings included: A record review of Resident #1's undated face sheet reflected a [AGE] year-old female admitted on [DATE] and discharged on [DATE] with diagnoses of benign neoplasm of pituitary gland (abnormal noncancerous growth), gout (excessive uric acid), muscle weakness, hyperlipidemia (high cholesterol), depression, edema (fluid buildup), chronic kidney disease, unspecified convulsions, type 2 diabetes, spinal stenosis (narrowing of spinal column), hypothyroidism (underactive thyroid), morbid (severe) obesity and chronic pain syndrome. A record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated moderately impaired cognition. A record review of Resident #1's care plan last revised on 3/14/2024 reflected the following: My/family's discharge planning will begin on day of admission including preparation for education and/or equipment. A record review of Resident #1's document dated 3/14/2024 titled 30 DAY NOTICE OF TRANSFER/DISCHARGE reflected Resident #1 would be discharged due to non-payment on 4/13/2024. A record review of Resident #1's order dated 4/12/2024, timed 10:48 a.m., and authored by the Nurse Practitioner reflected it was Okay to d/c pt to Group Home. A record review on 4/15/2024 of Resident #1's undated document titled Discharge Planning Review v1.0 reflected her advance directives and that she was not independent prior to admission. The following sections were blank: (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Who initiated the discharge -Reason for discharge -Recap of the resident's stay -:Living arrangements prior to admission -Initial discharge goals -Where resident discharged to at time of discharge -Resident's goals of care and treatment preferences -Resident's interest in receiving information regarding returning to the community -Number of times the resident was admitted to the hospital in the past 6 months -Whether resident had a caregiver at time of admission -Whether resident would have a caregiver after discharge -Discharge home services -Discharge goal barriers -Medication reconciliation information -Post-discharge medication list discussion with resident/family -Whether post-discharge medication list was provided to resident/family -Overall summary of discharge -Self-care evaluation and equipment including walking, wheelchair use, transfers, bathing, dressing, using the restroom, preparing meals, eating, grocery shopping, housekeeping, performing home maintenance, obtaining transportation, scheduling medical appointments, getting and taking medications, performing special treatments, procedures, and equipment and supplies Learning and care needs -Contacts and discharge information -Resident signature, resident representative signature, and staff signatures A record review of Resident #1's progress notes from April of 2024 reflected no notes from the SW on discharge planning and preparation. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 12:52 p.m., Resident #1's family member stated the facility could not find medical necessity for Resident #1 to be eligible for Medicaid and that she went to a boarding home on 4/12/2024. During an interview on 4/15/2024 at 12:55 p.m., the SW stated the facility had worked with Resident #1's family member on making payments but it was not enough for them to not discharge Resident #1 from the facility. The SW stated the process for facility-initiated discharges depended. The SW stated she ensured discharges were safe by making several referrals to other facilities and for Resident #1, she was able find another facility quickly. The SW stated Resident #1 was issued a 30-day notice due to non-payment. During an interview on 4/15/2024 at 1:50 p.m., the Nurse Practitioner stated, All I knew was that [Resident #1] was issued a 30-day notice due to non-payment so they told me she had to be transitioned to a different facility. The Nurse Practitioner stated no she was not involved with Resident #1's discharge planning and said she did not know Resident #1 was being discharged until the day of her discharge, on 4/12/2024. The Nurse Practitioner stated herself or the Medical Director would sign off on discharges. The Nurse Practitioner stated they should complete residents' discharge planning upon discharge and said she felt like it should be done before to anticipate the discharge and know where [Resident #1] was going. In regard to Resident #1's discharge planning and discharge summary not being completed, the Nurse Practitioner stated, that's not appropriate and it should have been done. During an interview on 4/15/2024 at 2:14 p.m., the SW stated she was not in the building when Resident #1 was discharged and said the ADON transported the resident to her new facility. During an interview on 4/15/2024 at 2:16 p.m., the MDS Coordinator stated the SW did all discharge planning for residents and no ma'am she was not involved at all with Resident #1's discharge. During an interview on 4/15/2024 at 2:30 p.m., the ADON stated discharge planning started when you walk in the door. The ADON stated LVN A was the one who took care of Resident #1 the day she was discharged (4/12/2024). The ADON stated the discharge planning task was open prior to residents being discharged and none of us knew where she was going. When asked why that was, the ADON stated, I don't know. The ADON stated not having the discharge summary completed upon a resident's discharge would result in lack of documentation but would not affect care. The Medical Director's contact information was requested on 4/15/2024 at 1:44 p.m. but was not provided before exit. During an interview on 4/15/2024 at 3:47 p.m., the Administrator stated Resident #1's discharge was a little different. The Administrator stated Resident #1 was given two discharge notices, the facility was trying to work with Resident #1's family member, and Resident #1's family member was not using her money correctly. The Administrator stated the SW was responsible for completing the discharge planning and summary. The Administrator stated himself, the SW and the DON were involved with Resident #1's discharge. When asked if failing to document Resident #1's discharge planning in her chart would have the potential to affect her, the Administrator stated, not necessarily if everything was done. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 3:54 p.m., the DON stated the discharge planning review was supposed to be opened upon admission and closed upon discharge. The DON stated, it's a recap of their stay. The DON stated there as a discharge note they're supposed to do and she was not sure why LVN A did not complete the note . The DON stated the expectation was that the discharge summary was to be completed, which consisted of the discharge planning review and a progress note completed by the nurse. The DON stated, we wouldn't discharge someone who was unsafe. A record review of the facility's undated policy titled Transfer or Discharge, Preparing a Resident For reflected the following: Policy Statement Residents will be prepared for discharge. Policy Interpretation and Implementation . 2. A post-discharge plan is reviewed with the resident, and/or his or her representative (responsible party) upon resident's discharge or transfer from the facility as applicable. 3. Nursing services is responsible for: b. Reviewing the post-discharge plan; d. Providing the resident and/or representative (responsible party) with discharge information. h. Informing appropriate departments of the resident's transfer or discharge

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45830 Based on interview and record review, the facility failed to provide appropriate timing of notice before transfer for one (Resident #1) of 8 residents reviewed for discharge notices. The facility failed to provide notice at least 30 days before Resident #1 was discharged on [DATE]. This failure placed residents at risk of being improperly discharged . Findings included: A record review of Resident #1's undated face sheet reflected a [AGE] year-old female admitted on [DATE] and discharged on [DATE] with diagnoses of benign neoplasm of pituitary gland (abnormal noncancerous growth), gout (excessive uric acid), muscle weakness, hyperlipidemia (high cholesterol), depression, edema (fluid buildup), chronic kidney disease, unspecified convulsions, type 2 diabetes, spinal stenosis (narrowing of spinal column), hypothyroidism (underactive thyroid), morbid (severe) obesity and chronic pain syndrome. A record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated moderately impaired cognition. A record review of Resident #1's care plan last revised on 3/14/2024 reflected the following: My/family's discharge planning will begin on day of admission including preparation for education and/or equipment. A record review of Resident #1's document dated 3/14/2024 titled 30 DAY NOTICE OF TRANSFER/DISCHARGE reflected Resident #1 would be discharged due to non-payment on 4/13/2024. A record review of Resident #1's progress note dated 3/15/2024 authored by the SW reflected the following: on 3/15/2024 the BOM, SW, and ED (Executive Director) had a phone conversation with [Resident #1's family member] to give her updates. The patient will have to DC on 4/13/24. A record review of Resident #1's order dated 4/12/2024, timed 10:48 a.m., and authored by the Nurse Practitioner reflected it was Okay to d/c pt to Group Home. During an interview on 4/15/2024 at 12:52 p.m., Resident #1's family member stated Resident #1's last day was supposed to be 4/13/2024 but they dropped her off at the boarding home Friday (4/12/2024). During an interview on 4/15/2024 at 12:55 p.m., the SW stated the BOM handled 30-day discharge notices and she spoke with Resident #1's family member the day of her discharge on 4/12/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 1:50 p.m., the Nurse Practitioner stated, All I knew was that [Resident #1] was issued a 30-day notice due to non-payment so they told me she had to be transitioned to a different facility. The Nurse Practitioner stated she did not know Resident #1 was being discharged until the day of her discharge, on 4/12/2024. The Nurse Practitioner stated, from my understanding, corporate was pushing for her to be gone within 24 hours and said the ADON had asked her to write Resident #1's discharge order on 4/12/2024. The Nurse Practitioner stated she heard from the Administrator that corporate only gave them 24 hours to get [Resident #1] out of the facility. During an interview on 4/15/2024 at 3:47 p.m., the Administrator stated Resident #1's discharge was a little different. The Administrator stated Resident #1 was given two discharge notices , the facility was trying to work with Resident #1's family member, and Resident #1's family member was not using her money correctly. When asked why Resident #1 was discharged on [DATE] when her chart indicated she was to be discharged on [DATE], the Administrator stated because Resident #1's family member would not assist the facility with finding a location . When asked if the facility's corporation gave him 24 hours to discharge Resident #1, the Administrator stated, it's been ongoing for 90 days. A record review of the facility's undated policy titled Transfer or Discharge, Preparing a Resident For reflected the following: Policy Statement Residents will be prepared for discharge. Policy Interpretation and Implementation 1. When a resident is scheduled for transfer or discharge, the facility will coordinate the transfer or discharge so that appropriate procedures can be implemented.