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	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 one (Resident #1) of five residents reviewed for pressure injuries. The facility failed to: - Complete weekly skin assessments for Resident #1 or provide treatments from 04/18/25 - 05/06/25 to a pressure area on his left foot which developed into a pressure wound. - Provide wound care consistently to Resident #1's sacral wound causing it to worsen. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 05/06/25 at 4:54 PM, and an IJ template was given. While the IJ was removed on 05/07/25 at 3:45 PM, the facility remained out of compliance at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including complete paraplegia (a form of paralysis that affects the lower half of the body), muscle weakness, and sepsis (a serious condition when the body has an extreme reaction to an infection) to sacral wound. Review of Resident #1's EMR, on 05/06/25, reflected neither his admission nor 5-day MDS assessment had not been completed. Review of Resident #1's EMR, on 05/06/25, reflected his baseline care plan had not been completed. Review of Resident #1's admission skin assessment, dated 04/15/25, reflected he had open areas/lesions: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675118	A. Building B. Wing	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Stage IV pressure ulcer to the sacrum measuring 6.8 cm x 4.7 cm x 5.9 cm. Unstageable pressure area to the left heel measuring 6.0 cm x 8.5 cm x nmcm. Review of Resident #1's Braden Scale, dated 04/16/25, reflected a score of 15, indicating he was a mild risk of developing pressure injuries. Review of Resident #1's physician order, dated 04/15/25, reflected treatment to sacrum: stage 4 pressure: Cleanse wound bed with normal saline or wound cleanser. Pat dry. Apply skin prep to peri wound. Cut foam to fit shape of wound. Place foam in wound bed. Cut foam to buttocks. Cut and apply transparent dressing over foam. Cut a dime size hole in transparent dressing over foam. Apply suction bell/pad over cut hole. Connect the dressing tubing to wound vac. Turn on wound vac to 124mmgh continuous very day shift every Monday, Wednesday, and Friday. Review of Resident #1's TAR, April of 2025, reflected he did not receive treatment to his sacral wound on 04/18/25 and 04/28/25 (two of seven opportunities). Review of Resident #1's TAR, May of 2025, reflected he did not receive treatment to his sacral wound on 05/05/25 (one of two opportunities). Review of Resident #1's physician order, dated 04/16/25, reflected treatment to left heel: unstageable (due to necrosis): Cleanse wound bed with normal saline or wound cleanser. Pat dry. Swab wound bed with betadine. Leave open to air every day shift and as needed. Review of Resident #1's TAR, April of 2025, reflected he did not receive treatment to his left heel on 04/20/25, 04/27/25, 04/28/25, and 04/29/25 (four of 14 opportunities). Review of Resident #1's TAR, April of 2025, reflected he did not receive treatment to his left heel on 05/03/25 and 05/05/25 (two of five opportunities). Review of Resident #1's WCD assessment, dated 04/21/25, reflected a stage 4 pressure wound to his sacrum, measuring, 6.5 cm x 5.5 cm x 5.0 cm (surface area 35.75 cm). There was no assessment of the pressure area to his left heel. Review of Resident #1's WCD assessment, dated 04/30/25, reflected a stage 4 pressure wound to his sacrum, measuring, 6.5 cm x 6 cm x 4.0 cm (surface area 39.0 cm). There were no assessments of the pressure area to his left heel. From his admission skin assessment on 04/15/25 his wound increased from the surface area measuring 31.96 cm to 39.0 cm on 04/30/25. Review of Resident #1's WCD assessment, dated 05/05/25, reflected his visit had been rescheduled. Review of Resident #1's assessments in his EMR, on 05/06/25, reflected no weekly skin assessments had been conducted since the initial skin assessment upon admission. (continued on next page)

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	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observation and interview on 05/06/25 at 10:22 AM revealed Resident #1 laying in his bed with his wound vac on and running. He stated he was not sure if he had a wound to his left heel because, due to his paralysis, he could not feel anything. He stated no one had been treating his left heel. He stated the WCD did not see him the day before (05/05/25) because he was eating lunch in the dining room. He stated when he went back to his room, he was told the WCD had already left for the day. He stated he did not believe his wound vac was changed three times a week, but did state it had been changed a few times. He stated it would be okay for his left heel to be observed after lunch. During a telephone interview on 05/06/25 at 11:30 AM, Resident #1's NP stated her expectations were that weekly skin assessments were done weekly by the WCD. She stated if the WCD could not complete an assessment, for whatever reason, the nurses should be conducting the assessment. She stated if resident's skin/wounds were not monitored, they could get worse. She stated if a resident missed one wound vac treatment in a week, they would be okay. During a telephone interview on 05/06/25 at 12:42 PM, the WCD stated he completed wound assessments on the residents weekly. He stated he was at the facility the day prior (05/05/25) and he was told the wound vac had already been changed so he did not complete an assessment because he assumed the nurse who changed the wound vac had completed one. He stated weekly skin assessments were important to determine if there were any changes or if anything was worsening. He stated if a resident had a pressure area, he would expect to be notified so he could assess the area weekly. He stated he was not aware Resident #1 had a pressure area to his left heel. During an interview on 05/06/25 at 1:55 PM, the DON stated it was her second day at the facility. She stated weekly skin assessments should be completed by nurses weekly, regardless of if the resident was seen by the wound care doctor. She stated it was important for the nurses to see all areas of the skin to ensure it was intact. She stated if not, something could be missed or go untreated. She stated it did not meet her expectations that any skin treatments get missed. An observation and interview on 05/06/25 at 2:00 PM revealed Resident #1 laying in his bed. This Surveyor asked permission to have a nurse help to observe his left foot and he agreed. LVN A and the DON entered the room and stated she (LVN A) did wound care rounds with the WCD weekly. She stated she was not sure if the WCD had been assessing his left foot. LVN A left the room and this Surveyor requested she (DON) remove Resident #1's pressure-relieving boot and sock from his left foot. The sock appeared dirty, and she had a difficult time taking it off. When the sock was removed, there was a dressing on his left heel dated 04/18/25. The DON's face was shocked, and she stated having a dressing on with a date from weeks ago, did not meet her expectations. While the DON began peeling/ripping the dressing off, flakes of dislodged skin were seen all around his foot. When the dressing was fully removed, there was a full thickness open wound surrounded by thick white peeling edges with irregular shaped black peri wound. During an interview on 05/06/25 at 3:32 PM, LVN A stated the WCN walked out two weeks ago, and she was trying to pick up the pieces. She stated her first time rounding with the WCD was the week prior. When asked why she had been checking off the treatment to Resident #1's left foot in his TAR, she stated it had been a mistake, she felt horrible, and she could not believe she had missed that. She stated she did not even know why he had a bandage to his left heel because upon admission there was just brown eschar to the area. She stated since they did not have a WCN, skin assessments should be done weekly by the floor nurses. She stated all orders should be followed and completed as ordered and it was unacceptable what happened to Resident #1's heel. (continued on next page)

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	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Pressure Ulcers/Skin Breakdown Policy, revised April of 2018, reflected the following: . 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. Review of the facility's Prevention of Pressure Ulcers/Injuries, revised July of 2017, reflected the following: . Risk Assessment: . 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. . b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) . Monitoring: 1. Evaluate, report and document potential changes in the skin. The ADM and DON were notified on 05/06/25 at 4:54 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/07/25 at 10:17 AM: All items listed will be completed by 7:00PM on 5/6/2025 with continued follow-up for scheduled staff. 1.R#1 immediately received a head-to-toe assessment including skin by the DON, findings of a worsening left heel were relayed to Medical Director and new orders received to clean wound with normal saline, pat dry, apply alginate with silver and cover with non-adherent dressing daily. 2. Findings were relayed to the Medical Director immediately. 3. Emotional Distress Assessment completed for R#1 by the Social Worker on 5/6/2025 with no emotional distress observed. (continued on next page)

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	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. R#1's Care Plan was updated by Corporate MDS Nurse regarding wound care and observations to be performed by staff. All nursing staff were in-serviced including PRN, agency staff and all newly hired staff prior to their shift. 5. On 5/6/2025 charge nurses on staff conducted a 100% skin audit on 78 residents overseen by the DON. Charge nurses were in-serviced on proper skin assessment by the DON prior to the conduction of assessments. No other residents were identified as having unidentified skin issues. 6. Administrator/DON initiated Staff in-service for ALL NURSING STAFF on 5/6/2025 on Prevention of Pressure Ulcers, Pressure Ulcers/Skin Breakdown - Clinical Protocol & Abuse and Neglect. DON trained by VP of Clinical Services prior to start of in-service on 5/6/2025 If staff are unable to attend any of the in-services, they will be required to complete them before starting their assigned shift to include PRN staff, agency staff and any new hires. The Medical Director was first made aware of the Immediate Jeopardy 5/6/2025 at 5:45:00PM and has been involved in developing the Plan of Removal. These conversations are considered a part of the QA process. A QAPI meeting was held on 5/6/2025 with attendance of the Company President, Director of Nursing & VP of Clinical Services. This plan was initially implemented 5/6/2025 and will be monitored through completion by corporate staff. Plan of Removal completion date is 5/7/2025 by 5:00 pm with continuation of oncoming staff and follow up. The Surveyor monitored the POR on 05/07/25 as followed: Observations on 05/07/25 from 2:14 PM - 2:48 PM revealed the VPO conducting a skin assessment on two residents. Both had skin that was intact, no redness, and no concerns. During interviews on 05/07/25 from 11:09 AM - 3:25 PM, four LVNs and three CNAs from different shifts all stated they had been in-serviced before working the floor. The nurses were able to describe how to conduct a head-to-toe skin assessment and the importance of them being completed once a week. The nurses all stated they looked for skin tears, open areas, redness, and focused on areas such as heels and the coccyx. The nurses stated they would notify the NP immediately of any new skin concerns and that weekly skin assessments were important to ensure there were no new skin areas and wounds were not worsening. The nurses stated it was important to ensure staff were only signing off on orders they completed. The aides stated whenever they gave care or showers to residents, they were to notify the nurses immediately of any changes in the skin such as rashes, bruises, or redness. The aides stated any kind of bath/shower, including a bed bath, should include washing the whole body, including the residents' feet. Review of the facility's QAPI minutes, dated 05/06/25, reflected the ADM, the DON, the MDSC, and the MD were in attendance. Review of Resident #1's Emotional Distress Assessment, dated 05/06/25 and conducted by the SW, reflected no emotional distress observed. (continued on next page)

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	05/07/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of five residents' EMRs (including Resident #1), on 05/07/25, reflected a weekly skin assessment had been conducted on 05/06/25 with no concerns. Review of Resident #1's physician order, dated 05/06/25, reflected to cleanse the left heel with normal saline, apply alginate with silver, and cover with non-adherent dressing every day shift. Review of Resident #1's TAR, May 2025, reflected treatments had been completed on 05/06/25 and 05/07/25 to both his sacral and heel wounds. Review of Resident #1's initial care plan, initiated 05/07/25, reflected he was at risk for complications related to existing wounds (sacral stage IV and unstageable to left heel) with interventions of weekly and PRN skin assessments. Review of an in-service, dated 05/06/25 - 05/07/25 and conducted by the DON, reflected all nurses were being in-serviced on weekly skin assessments, wound treatments, pressure ulcer prevention, comprehensive care plans, and abuse and neglect. Review of an in-service, dated 05/06/25 - 05/07/25 and conducted by the ADM, reflected all aides were being in-serviced on recognizing skin changes and informing their charge nurses. The ADM and ADON were notified on 05/07/25 at 3:45 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.