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	08/05/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan 7 days after each comprehensive assessment and no more than 21 days after admission for 2 of 5 residents (Residents #1 and Resident #2) reviewed for care plan revision and timing. 1. The facility failed to updated Resident #1's care plan to reflect Resident #1's foley catheter was removed in 2023. 2. The facility failed to implement a comprehensive care plan for Resident #2. This failure placed residents at risk of not receiving the appropriate care and services to maintain the highest practical well-being. Findings include: Review of Resident #1 face sheet reflected an [AGE] year-old man admitted on [DATE] with diagnoses of unspecified dementia (group of symptoms affecting memory, thinking, and social abilities), depression (mood disorder that causes persistent feelings of sadness and loss of interest in activities), dysphagia (difficulty swallowing), and type 2 diabetes (chronic condition where the body doesn't properly use insulin to regulate blood sugar). Review of Resident #1's care plan dated 09/27/2023 reflected Resident #1 had an indwelling foley catheter. Goal included catheter would be removed, when possible, over next 90 days with target date of 11/25/2025. Further review of care plan dated 09/26/2023 reflected Resident #1 was a new admission to SNF with goal to adjust to facility with target date of 11/25/2025. Review reflected Resident #1 had impaired cognitive function and required 1:1 staff assistance with toileting and hygiene. Review of Resident #1's orders reflected an order for catheter care every shift was discontinued on 10/02/2023. Review of Resident #1's NP progress note dated 10/05/2023 reflected foley catheter was discontinued. Review of Resident #1's quarterly MDS dated [DATE] reflected Resident #1's BIMS was not conducted as he was rarely or never understood. Review of MDS section H reflected none of the above was selected for bowel and bladder appliances. Indwelling catheter was not selected. Review of Resident #1's orders reflected an order for catheter care every shift was discontinued on 10/02/2023. Review of Resident #1's NP progress note dated 10/05/2023 reflected foley catheter was discontinued. Observation and attempted interview on 08/04/2025 at 11:16 AM revealed Resident #1 sat in the dining room with no foley bag observed on his wheelchair or leg. Resident #1 was unable to answer questions and mumbled as residents approached him. Review of Resident #2's face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage in brain stem (stroke where bleeding occurs within the brain stem), malignant neoplasm of prostate (prostate cancer), alcoholic cirrhosis of liver (breakdown of the liver due to alcohol use) and type 2 diabetes (chronic condition where the body does not properly use insulin to regulate blood sugar). Review of Resident #2 quarterly MDS dated [DATE] reflected a BIMS score of 11 which indicated a moderate cognitive impairment. Review of Resident #2's baseline care plan reflected a date of 05/24/2025. Review reflected Resident #2 was always incontinent of bowel and bladder. Review of Resident #2's chart on 08/05/2025 reflected he had no comprehensive care plan created. Resident #2 comprehensive care plan should have been created 21 days after admission on [DATE]. During an interview on 08/05/2025 at 3:01 PM, LVN A stated that cares are generated by an RN and include any devices a resident had and had information to care for the resident. During an interview on 08/05/2025 at 3:28 PM, the DON stated that for the comprehensive care plan, each discipline completed their section and stated that wounds were care planned by the wound nurse, antibiotics by the MDS coordinator and room information by the social worker. The DON stated that the MDS coordinator was responsible to start the comprehensive care plan. The DON stated that she expected every resident to have a care plan in place. The DON stated that the importance of the care plan was to monitor any changes and the resident's condition. The DON stated it showed the residents' baseline at admission and evaluates their status quarterly. The DON stated the care plan was updated quarterly. The DON stated that she did not think there was a definitive person that audited that care plans were updated or completed behind the MDS coordinator, but the DON reviewed care plans sporadically. During an interview at 08/05/2025 at 5:17 PM, LVN B stated that a care plan included general needs of the resident, behaviors, ADL needs and bowel and bladder information. LVN B stated that a care plan has the residents needs to be cared for. During observation and interview on 08/05/2025 at 3:47 PM, the MDS coordinator stated that her role for the comprehensive care plan was to open up or create the care plan if the resident was a new admission. The MDS coordinator stated that she updated the care plan with triggers from the MDS. The MDS coordinator stated that the care plan was also a working document and can be updated as things come up such as dietary changes or