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	01/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs are stored properly and only authorized persons have access for 1 of 4 medication carts (MC #1) reviewed for drug storage and labeling.The facility failed to ensure MC #1 was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included:During an observation of the nurses' station on 01/07/2026 at 11:32 a.m., revealed MC#1 was unlocked and unattended. A nurse was sitting inside the nurses' station out of view of the medication cart. Residents and staff were walking by the unlocked medication cart. MC #1 contained residents prescribed creams, residents prescribed drugs, over the counter medication, narcotics, catheters, and breathing machine medication. During an interview with LVN A on 01/07/2026 at 11:40 a.m., revealed that he had been trained on medication storage. He said the medication cart policy was staff must lock the medication cart anytime they walked away. He said that the nurse was responsible for locking the medication cart. He also said any staff who walked by could lock the medication cart. He said if the medication cart was left unlocked and unattended a resident might get into the medication cart. He said the DON and ADM monitored to ensure staff were locking the medication carts. He said the DON and ADM monitored by doing observations to ensure the medication carts are locked. He said he did not know why he left the medication cart unlocked. During an interview with the DON on 01/07/2026 at 4:52 p.m., revealed she had been trained on medication storage. She said the medication cart policy was staff must lock the medication cart any time the staff member was not using the cart. She also said staff were to lock the medication cart even if they stepped away for a moment. She said the nurses or the medication aide who was assigned to the medication cart was responsible for ensuring the medication cart was locked. She said the DON and the ADM monitor to ensure the staff lock the medication carts. She said the DON and ADM monitor by doing observation rounds. She said she thought LVN A may have gotten busy or distracted. During an interview with the ADM on 01/07/2026 at 4:58 p.m., revealed she had been trained on medication storage. She said the medication cart policy was the medication cart needed to be always locked when the nurse or medication aide was not using the medication cart. She said the medication aid or nurse on the medication cart was responsible for locking the cart. She also said any staff that saw a medication cart unlocked could lock the medication cart. She said the nursing management team monitored to ensure the medication carts were locked. She said the nursing management team walked through the halls to check the medication carts to ensure the carts were locked. She said she did not know why LVN A did not lock the medication cart. Record review of Storage of Medication Policy dated 4/2019, revealed Drug and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Compartments (including, but not 1imited to, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals arc locked when not in use. Unlocked medication carts are not left unattended.