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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review the facility failed to ensure resident rights for personal privacy for 5 of 5 residents (Resident #2, Resident #3, Resident #16, Resident #25, and Resident #54) residents reviewed for personal privacy. The facility failed to knock on Resident #2, Resident #3, Resident #16, Resident #25, and Resident #54's door when going into the residents' rooms. The deficient practice could affect all residents right to privacy in the facility and cause the resident to feel like their privacy is being invaded or the facility is not their home. Findings included: Review of Resident #2's Face Sheet dated 07/23/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included atherosclerosis of native arteries of extremities (arteries are blocked), osteoporosis (weak and brittle bones), cognitive communication deficit (problems with communication), anxiety disorder, history of falling, contracture joint (permanently bent), spinal stenosis (spaces inside the bones of the spine get too small), gastroesophageal reflux disease without esophagitis (reflux), irritable bowel, retention of urine, lipoprotein metabolism (particles made of fat and protein that travel through the blood stream), hyperlipidemia (high cholesterol), Arthritis, physical debility, chronic pain, hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), muscle weakness, muscle wasting, and abnormalities with gate and mobility. Record Review of Resident #2's Quarterly MDS dated [DATE] revealed that Resident #2 had a BIMS score of 15, indicating the resident could understand and make self-understood. Review of Resident #3's Face Sheet dated 07/23/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included, dementia (memory, thinking, difficulty), depression, hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), lack of coordination, abnormalities of gait and mobility, unsteadiness on feet, muscle wasting, cognitive communication deficit (problems with communication), dysphagia (difficulty swallowing), hyperthyroidism (excessive production of thyroid hormones), gastroesophageal reflux disease without esophagitis (reflux), iron deficiency, insomnia (difficulty sleeping), hyperkalemia (high potassium levels in the blood), lack of coordination, and protein calorie malnutrition. (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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #3's quarterly MDS dated [DATE] revealed that Resident #3 had a BIMS score of 7, indicating the resident could not understand or make self-understood at times. Review of Resident #16's Face Sheet dated 07/23/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #16's diagnoses included dementia (memory, thinking, difficulty), dysphagia (difficulty swallowing), urinary tract infection, depression, gastroesophageal hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), reflux disease without esophagitis (reflux), morbid obesity, muscle weakness, shortness of breath, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), kidney disease, benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate), obstructive and reflux uropathy (blocked urine flow), neuropathic bladder (bladder issues due to nerve problems), muscle wasting, and anxiety disorder. Record Review of Resident #16's quarterly MDS dated [DATE] revealed that Resident #16 had a BIMS score of 10, indicating the resident could understand or make self-understood at times. Review of Resident #25's Face Sheet dated 07/23/2024 revealed he was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26's diagnoses included peripheral nervous system (damage to motor nerves), major depressive disorder (mental disorder), Tremors, visual disturbance, anxiety, dry eye, delusional disorder, psychosis, convulsions, pain in right shoulder, constipations, magnesium disorder, muscle weakness, chronic pain, obesity, dysphagia (difficulty swallowing), type 2 diabetes mellitus with unspecified complications (high blood sugar), hypertension (high blood pressure), hyperlipidemia (high cholesterol), paranoid schizophrenia (mental disorder), and bipolar disorder (extreme mood swings). Record Review of Resident #25's quarterly MDS dated [DATE] revealed that Resident #25 had a BIMS score of 15, indicating the resident could understand or make self-understood all the time. Review of Resident #54's Face Sheet dated 07/23/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #54's diagnoses included dementia (memory, thinking, difficulty), urinary tract infection (infection of urine), attention and concentration deficit, encounter of immunization, lack of coordination, weakness, unsteadiness on feet, obstructive pulmonary disease (chronic progressive lung disease), abnormalities of gait and mobility, osteoarthritis (joint disease), dysphagia (difficulty swallowing), pain in right hip, major depressive disorder, hyperlipidemia (high cholesterol), irritable bowel syndrome, insomnia (difficulty sleeping), overactive bladder, iron deficiency, gastroesophageal reflux disease without esophagitis (reflux), type 2 diabetes mellitus without complications (high blood sugar), hypertension (high blood pressure), history of falling, muscle wasting, muscle weakness, and cognitive communication deficit (problems with communication). Record Review of Resident #54's quarterly MDS dated [DATE] revealed that Resident #54 had a BIMS score of 09 indicating the resident could not understand or make self-understood all the time. Observation of hall trays being passed on 07/21/2024 at 12:52pm revealed CNA A not knocking on Resident #3, Resident #16, or Resident #54's doors before entering the room. (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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of hall trays being passed on 07/22/2024 at 12:09pm revealed CNA B not knocking on Resident #2 and Resident #25's doors before entering the room . An interview with Resident #54 on 07/23/2024 at 10:08am revealed that staff do not always knock on her door before entering. She stated she was not sure how often staff did not knock. She stated it would be nice for the staff to knock before entering the room. She said she was not sure how she felt about staff not knocking before entering her room. An interview with Resident #25 on 07/23/2024 at 10:13am revealed that staff sometimes knock and sometimes they do not knock. She stated male staff do not knock on the door before entering. She stated it was not necessary for staff to knock all the time but if she was not dressed, she would want the staff to knock before coming in her room. She stated that if staff do not knock before entering, she gets very upset. An interview with Resident 16 on 07/23/2024 at 10:20am revealed that staff do not always knock. He stated that he would like for the staff to knock before entering his room. He stated in the past a staff member walked in while he was asleep and took covers off him and it startled him. He stated staff walk in without knocking a couple of times a week. He stated it makes him nervous when staff just walk in without knocking because most of the time, he is asleep. An interview with Resident #3 on 07/23/2024 at 10:42am revealed that staff knock on her door unless her door is open. She stated that she did not know how often staff walked into her room without knocking. She stated that it does not bother her if the staff do not knock on her door before entering. An interview with CNA B on 07/23/2024 at 10:31am revealed she had been trained on resident rights and privacy. She stated that staff were supposed to knock and introduce themselves before entering a resident's room. She stated that it was important to knock before entering to give the resident privacy. She stated if you do not knock, it could make the resident feel as if staff were invading their privacy. She stated that she did not know why she did not knock and that she should have. She stated that sometimes it was hard to hold the tray and knock on the door. An interview with the CNA B on 07/23/2024 at 10:39am revealed that she had been trained on resident rights and privacy. She stated that the policy was staff were to knock and announce themselves and what they were there to do for the resident. She stated everyone who was going into the resident's room was supposed to knock. She stated it was important to knock before entering to ensure staff were not invading the resident's privacy. She stated if staff did not knock the resident may be unaware the staff were there, and the resident may feel like staff did not respect them. She stated that she did not knock on the door because it was open. She also stated that she should have knocked. An interview with the DON on 07/23/2024 at 12:59am revealed she had been trained on resident rights and knocking on the resident's door before entering. She said all staff were required to knock on the resident's door before entering their room. She stated it was important to provide them with their privacy and dignity and allow the time for entrance to ensure residents were not exposed. She stated that the facility was the resident's home and that no one would like someone entering their home without knocking. She stated staff could have still knocked on the resident's door before taking the tray out of the cart. (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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADM on 07/23/2024 at 11:54am revealed staff were supposed to knock before entering a resident's room. He stated all staff were supposed to knock before entering a resident's room. He said that it was important to knock before entering because the facility is their home. He stated that if staff did not knock on the door before entering the resident may feel unappreciated or disrespected, because staff were not knocking before going into their home. He stated he did not know why staff did not knock on the resident's door before entering. He also stated the facility did not have a policy for knocking on the resident's door. Record review Residents Rights Policy Statement not dated revealed residents have the right to privacy and confidentiality.

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	07/23/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observations, interviews, and record review the facility failed to ensure the safe handling, humidification, cleaning, storage, and dispensing of oxygen for respiratory care services provided to 3 of 3 residents The facility failed to ensure Resident's oxygen tubing was dated to ensure it was changed weekly for 3 residents (Residents 9, 16, and 25. The facility failed to have a written policy to ensure the safe handling, humidification, cleaning, storage, and dispensing of oxygen on 7/23/24. The facility failed to ensure that the humidifier bottle had water for Resident 25. This failure placed the residents at risk of developing a respiratory infection from contamination of the tubing and humidifier water. Findings included: A review of Resident 9's face sheet dated 7/23/24 reflected she was a [AGE] year-old female with a diagnosis of chronic obstructive pulmonary disease which blocks air flow in the lungs. her other diagnoses were dysphagia (difficulty swallowing), anemia, cerebral infarction (stroke), and congestive heart failure. A review of Resident 9's Quarterly Minimum Data Set, dated dated dated [DATE] reflected she had a BIMS (Brief Interview for Mental Status) score of 10 which indicated she was moderately cognitively impaired. A review of Resident 9's Care Plan reflected on 4/10/24, a focus area was initiated for shortness of breath associated with her congested heart failure and chronic obstructive pulmonary disease diagnosis. These diagnoses limit the circulating oxygen in the blood and the amount of oxygen flow in the lungs. The care plan reflected a goal to remain free of respiratory infections and interventions which included oxygen as ordered by the physician. A review of Resident 9's active orders reflected a 1/17/24 order, Apply oxygen as needed at 2-3 liters per minute per nasal canula every 6 hours as needed for shortness of breath or symptoms of respiratory distress. An additional order dated 1/20/24 reflected, Replace humidified water, oxygen tubing, and cleanse filter every night shift every Saturday -label, date, and bag supplies. A review of Resident 16's face sheet dated 7/23/24 reflected he was a [AGE] year-old male with diagnoses of shortness of breath, dementia, hypertensive heart disease, and chronic kidney disease. A review of Resident 16's Quarterly Minimum Data Set, dated dated dated [DATE] reflected he has a BIMS (Brief Interview for Mental Status) score of 10 which indicated he was moderately cognitively impaired. (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	07/23/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 16's Care Plan reflected on 4/10/24, a focus area was initiated for shortness of breath with a goal to remain free of complications related to shortness of breath. A review of Resident 16's active orders reflected a 3/5/24 order to apply oxygen 2-3 liters per minute via nasal canula as needed for hypoxia/maintain oxygen saturation above 92%. No order for cleaning/changing tubing was found in the orders. A review of Resident 25's face sheet dated 7/23/24 reflected she was a [AGE] year-old female with diagnoses of depression, muscle weakness, diabetes, hypertension (high blood pressure), and bipolar disorder. A review of Resident 25's Quarterly Minimum Data Set, dated dated dated [DATE] reflected she has a BIMS (Brief Interview for Mental Status) score of 15 which indicated she was cognitively competent. A review of Resident 25's Care Plan reflected on 10/4/22, a focus area was initiated for limited physical mobility related to weakness. A review of Resident 25's Orders reflected an order to change the humidifier water, oxygen tubing, and cleanse filter every night shift every Sunday. Observation on 7/21/24 at 10:45 a.m. revealed Resident 9's oxygen tubing and humidifier bottle was dated 7/14/24. Observation on 7/21/24 at 10:38 a.m. revealed Resident 16's oxygen tubing and humidifier bottle was dated 7/3/24. Observation on 7/21/24 at 10:09 a.m. revealed Resident 25's oxygen tubing and humidifier bottle was dated 6/30/24 and the bottle was empty of water. Observation on 7/22/24 at 9:52 a.m. revealed Resident 9's oxygen tubing and humidifier bottle was still dated 7/14/24. In an interview with the ICP on 7/23/24 at 11:13 am she stated, the policy on changing oxygen tubing and the humidifier bottle was to change on Sunday evening, if empty or if the nasal canula was soiled. She stated that an order was placed on the nurse MAR (Medication Administration Record) that tells nurses to change the tubing weekly. ICP stated an oxygen humidifier bottle should be at least 3/4 full and never empty. She further stated, if the doctor does not write an order for changing the tubing, then the staff call the nurse practitioner or the physician to get an order. The ICP stated, it was important to change the tubing so it would work properly and for infection control. She stated, the negative outcome to the residents if the tubing was not changed, would be infections or a drop in oxygen because the tubing may not function properly. (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	07/23/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 7/23/24 at 11:18 am she stated, the policy on changing oxygen tubing and the humidifier bottle was to change every 7 days and label and date the new tubing. When not in use, the tubing should be placed in a bag. The DON stated an order was placed on the nurse MAR that told the nurses to change the tubing weekly. The DON further stated, an oxygen humidifier bottle should be full up to the level indicated or to the minimum, but it should never be empty. She stated if the doctor does not write an order to change the tubing, then the staff should request an order. She stated it was important to change the tubing for infection control and to prevent bacteria from entering the body. She stated, the negative outcome to residents if the tubing was not changed, would be infections and hospitalization s. She stated that Resident 16 did not have an order to change the tubing because he left the facility and came back. She said the order needed to be added back for that resident. The DON stated the only policy for Oxygen was the Dynasty Health Care Group-Oxygen Administration policy given to the survey team. In an interview with the ADON on 7/23/24 at 11:30 am she stated, the policy on changing oxygen tubing and the humidifier bottle was to change every 7 days, usually on Sunday evenings. She stated that an order was placed on the nurse MAR (Medication Administration Record) that told the nurses to change the tubing weekly. She further stated, an oxygen humidifier bottle should be at least 50% or more full and never empty. She stated, if the doctor does not write an order for changing tubing, then the staff reach out to the nurse practitioner or call the doctor for the order. The ADON stated, it was important to change the tubing so it would not get kinked and to prevent air to flow thoroughly. She also stated, the negative outcome to residents if the tubing was not changed, would be possible infection or lack of oxygen. In an interview with LVN -A on 7/23/24 at 11:26 am she stated, the policy on changing oxygen tubing and the humidifier bottle was to change it once a week on night shift and an order was placed on the nurse MAR that tells nurses to change the tubing weekly. She stated, an oxygen humidifier bottle should be at least 1/2-2/3 full and never empty. LVN-A stated, if the doctor doesn't write an order for changing tubing, then the staff call and get a clarification order. She further stated, it was important to change the tubing for infection control and because the negative outcome to residents if the tubing was not changed, would be infections. A review of the undated 2-page Oxygen Policy labeled Dynasty Health Care Group-Oxygen Administration revealed that the policy failed to specify the safe handling, humidification, cleaning, storage, or dispensing of oxygen tubing and humidifier bottle, after the initial set-up. The policy did not indicate when tubing should be changed for infection control.

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	07/23/2024

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to provide the physician prescribed therapeutic diet to 1 of 4 residents (Resident #9) reviewed for therapeutic diets. Resident #9 did not receive a mechanical soft diet as ordered. This failure affected one resident and placed her at risk for choking and causing further health issues. The findings were: Record review of Resident #9's admissions record dated 07/23/2024 revealed that Resident #2 was admitted to the facility on [DATE]. Resident #9's diagnoses included cerebral infraction (long term effects of a stroke), lack of coordination, muscle weakness, dysphagia (difficulty swallowing), atrial fibrillation (abnormal heart rhythm), pressure ulcer of sacral region (wound on boney area on bottom), depression, cardiomyopathy (disease of the heart muscles), anemia (not enough healthy red blood cells), morbid obesity, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), allergic rhinitis (allergies), obstructive pulmonary disease (chronic progressive lung disease), gastroesophageal reflux disease without esophagitis (reflux), constipation, chronic pain, hemiplegia and hemiparesis following cerebrovascular disease (paralysis and weakness), type 2 diabetes mellitus with other specified complications (high blood sugar), and heart disease. Record review of Resident #9's quarterly MDS dated [DATE] revealed Resident #9's BIMS score was 11 which indicated that Resident #9 could understand and makes self-understood most of the time. The MDS also revealed that the resident needed set up and clean up assistance with eating. Record review of Resident #9's diet orders dated 01/19/2024 revealed the resident was on a regular mechanical soft/ground meats texture thin liquid consistency diet. Observation of dining services on 07/21/2024 at 1:13pm revealed that Resident #9 was given a regular diet tray. The meal was a whole breaded chicken patty, spaghetti noodles, mixed vegetables, and a roll. Resident #9's meal ticket stated, Regular diet mechanical soft/ground meats texture think liquid consistency . An interview with Resident #9 on 07/22/2024 at 9:52am revealed that she was on a regular diet. She stated that she gets a regular diet for all meals. (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	07/23/2024

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN B on 07/23/2024 at 10:54am revealed that the nurses were supposed to check the meal trays when they came out of the kitchen before it was given to the resident. She stated if the meal tray was not correct the nurse would send it back to the kitchen for the correct meal tray. She stated if a resident got the wrong diet the resident could have an allergic reaction and choke. She stated if there was a change in the resident's diet the nurse would put the change in the computer and take the slip to the kitchen staff. She stated she did not know why the resident was not given a mechanical soft diet and that the nurse should have caught the error. An interview with the DON on 07/23/2024 at 12:59pm revealed that the nurses should be checking the meal ticket with the tray to ensure the meal being served was correct. She stated if a resident had a change in diet the change would go to the dietary manager and the nurse manager. She stated staff could also look in the resident's orders to make sure the resident was getting the proper diet. She also said that if the resident did not get the correct diet the resident could aspirate, choke, or have an adverse reaction. She stated she did not know why Resident #2 did not get the correct diet. An interview with the ADM on 07/23/2024 at 11:54am revealed that nurses were to check the trays before they go out to verify the ticket matches what was on the tray. He stated nursing would put the order in and communicate that to the kitchen. He stated staff could look to see if the resident was getting the proper diet in the computer on the resident's information page. He said if a resident did not get the proper diet, it could cause the resident to choke, or get sick. He stated he did not know why Resident #2 did not get the proper diet. Record Review of Tray Identification Policy dated 04/2007 revealed nursing staff shall check each food tray for the correct diet before serving the resident.

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	07/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for foods safety for 1 of 1 kitchen reviewed for food safety and sanitation. The facility failed to ensure all food items were labeled and dated. The facility failed to ensure meat was properly thawed to the correct temperature. These failures placed residents at risk of foodborne illness. Findings included: An observation of the walk-in refrigerator on 07/21/2024 at 9:05 a.m. revealed approximately 25 fruit cups exposed to air and not labeled as to when prepped. A pan of ground meat that had been cooked without a label or date. A white bucket of boiled eggs was exposed to air and did not have a label or date as to when opened. Two trays of drinks exposed to air without a label and date on them. An observation of the walk-in freezer on 07/21/2024 at 9:08 a.m. revealed a plastic bag of chicken strips, hamburger patties, and English muffins that did not have a label and date as to when opened. An observation of the kitchen on 07/21/2024 at 9:38 a.m. revealed two long rolls of breakfast sausage were sitting in a pan and were warm when the package was touched. An interview with CK A on 07/21/2024 at 9:41am revealed that he was going to cook the sausage for the next day for breakfast. Observation of CK A on 07/21/2024 at 9:48am of him taking the temperature of the [NAME] Dean sausage rolls revealed that the temperature was 63 degrees. An interview with CK A on 07/21/2024 at 9:48am revealed that the sausage was not at correct temperature and that he was going to throw the sausage away. He stated if he cooked it the residents could get sick because it was not at the correct temperature of 41 degrees or below. He stated he was trained on temperatures when he did his food handlers class. Observation of the kitchen on 07/21/2024 at 12:30pm revealed that CK A did throw the sausage away and did not cook it. An interview with CK B on 07/23/2024 at 9:56am revealed that all kitchen staff were responsible for ensuring food was labeled and dated after opened. He stated that he had just done his food handlers and remembered the temperatures questions. He also stated that the proper temperature of thawed meat was 65 degrees. He stated that when thawing food, the cook was to run water over it in the sink. He stated that if food was not thawed correctly at the proper temperature and the food was not labeled and dated it would put residents at risk for getting sick . (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	07/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DM on 07/23/2024 at 10:06am revealed that when the facility would get a truck everything was supposed to be labeled and dated. She stated that the proper temperature for thawing food was 41 degrees. She stated by not thawing food correctly it could cause bacteria to grow. She stated that if food was not labeled and dated it could cause the residents to get sick and possibly die. She stated that staff were trained on temperatures when they get their food handlers cards. She also said that she would go over temperatures with the staff. She stated she did not know why the meat was not at the correct temperature . Record review of kitchen staff files did reveal staff had food handler card. Food handlers class covered temperatures. Record review of Food Storage Policy dated 2018 revealed to ensure freshness, store opened and bulk items in tightly covered container. All containers must be labeled and dated. Date label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Store frozen foods in moisture proof wrap or containers that are labeled and dated. Once frozen food has been thawed it must be maintained at 41 degrees or less prior to cooking. A record review of the FDA's 2022 Food Code reflected the following: 7-209.11 Storage. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .