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	08/21/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 3 of 15 residents (Resident #17, Resident #35, and Resident #80) reviewed for resident rights. The facility failed to ensure CNA A and LVN B knocked on Resident #17, Resident #35, and Resident #80's doors when going into the residents' rooms. The deficient practice could place residents at risk of poor self-esteem and feeling like their privacy was being invaded or the facility was not their home.Findings include: 1. Record review of Resident #17's admission sheet, dated 08/19/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included cystitis without hematuria (inflammation of the bladder), somatization disorder (tendency to experience and express psychological distress as physical symptoms), fusion of the spine (surgical procedure that connect two or more parts in the spine), muscle weakness, congenital malformation of nervous system (birth defect that affects the structure and development of the brain and spinal cord), lack of coordination, anxiety disorder (feeling of uneasiness or worry) and hypertension (high blood pressure). Record review of Resident #17's admission MDS assessment, dated 06/23/2025, revealed Resident #17 had a BIMS score of 13, which indicated intact cognitive response. Observation of hall meal tray pass on 08/19/2025 at 12:07 p.m., revealed CNA A did not knock on Resident #17's door before entering her room. During an interview with Resident #17 on 08/19/2025 at 11:01 AM revealed staff did not always knock on the door before entering. She said she would like for them to knock all the time before they entered her room. She said she did not get upset when they did not knock. 2. Record review of Resident #35's admission sheet, dated 08/19/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included muscle wasting, muscle weakness, glaucoma (eye disease), hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), gastritis (swelling of the lining of the stomach), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), lack of coordination, abnormalities of gait and mobility, and cognitive communication deficit (problems with communication). Record review of Resident #35's admission MDS assessment, dated 05/09/2025, revealed Resident #35 had a BIMS score of 13, which indicated intact cognitive response. Observation of hall meal tray pass on 08/19/2025 at 12:12 p.m., revealed LVN B did not knock on Resident #35's door before entering her room. During an interview with Resident #35 on 08/19/2025 3:45 PM revealed staff did not knock on the door all the time. She said she would like the staff to knock all the time. She said it bothered her when staff did not knock because it startled her. 3. Record review of Resident #80's admission sheet, dated 08/19/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #80 had diagnoses which included dementia (memory, thinking, difficulty), unsteadiness on feet, paroxysmal atrial fibrillation (irregular heartbeat that comes and goes), chronic obstructive pulmonary disease (chronic progressive lung disease), anxiety (feeling of uneasiness or worry), kidney disease, hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), hyperlipidemia (high cholesterol), abnormalities of gait and mobility, insomnia (difficulty sleeping) and cognitive communication deficit (problems with communication). Record review of Resident #80's Quarterly MDS assessment, dated 06/14/2025, revealed Resident #80 had a BIMS score of 15, which indicated intact cognitive response. Observation of halls on 08/20/2025 at 10:45a.m., revealed CNA A did not knock on Resident #80's door before entering her room. During an interview with Resident #80 on 08/19/2025 at 3:35 PM revealed staff did not always knock on the resident's door before entering. She said it bothered her when staff did not knock. She said she would like for staff to knock all the time before entering. During an interview with CNA A on 08/21/2025 at 1:16 PM revealed he was trained on resident rights. He stated the policy was to knock and introduce yourself before entering the resident's room because it was there home. CNA A stated staff should always knock on the door. He said anybody who wanted to go into the resident's room should be knocking. He said the residents did not like staff not knocking. He said it would be like just walking into the resident's house and that was not ok. He said no one monitored to ensure staff were knocking. He said they just had an in-service on knocking this week. He said he did not know why he did not knock on the residents' doors. During an interview with LVN B on 08/21/2025 at 1:30 PM revealed she was trained on resident rights. She said the policy was to knock and introduce

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review the facility failed to ensure the resident had a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident # 31) reviewed for medical record confidentiality.The facility failed to ensure RN D kept Resident # 31's medical information confidential.This failure could place residents at risk of their medical information being provided to unauthorized personnel, other residents, or visitors.Findings include: Observation on 08/20/2025 from 9:08 AM until 9:12 AM revealed RN D was not at the medication cart. The computer screen was left open and facing the hallway which exposed Resident confidential medical information which included name and medications. Interview on 08/20/2025 at 9:14 AM, RN D stated resident name and monitoring were on the open screen; however, he could not remember if his diagnosis was on the screen. He stated he received in-service to always lock the computer screen when not standing at the medication cart. He stated he did not recall the date he received the in-service on HIPPA. He stated he did not follow HIPPA protocol. RN D stated a visitor, another resident or anyone not an employee at the facility had access to a resident's medical information if they passed by the medication cart. He stated if another resident saw any information and shared with Resident #31, this may be embarrassing to the resident for other residents to see the resident's medical information. Interview on 08/21/2025 at 1:30 PM, the Administrator stated her expectation was for confidentiality of the residents to be protected. She stated computer screens should have been closed when not in use and any paperwork with the resident information should have been covered. She stated that was protected confidential information and it could have been a HIPAA violation.In an interview on 08/21/2025 at 2:50 PM, the DON stated resident information should be kept confidential and if it were not, it would be a HIPAA violation. She stated all computer screens were expected to be locked if a nurse was not viewing a resident's information. She said because if the screen is left open with the resident's information anyone could get that residents information. Record review of the facility's, undated, Policy on Protected Health Information, Safeguarding Electronic, reflected Electronic protected health information is safeguarded by administrative, technical, and physical means to prevent unauthorized access to protected health information. All workstations are protected from unauthorized access by physical barriers that discourage attempts to tamper with or violate security rules, including:a. Placing computer terminals and workstations away from high- traffic areas of the facility.Automatically locking computer screens.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 3 of 3 residents (Resident #48, Resident #68, and Resident #93) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #48's admission MDS, dated [DATE], accurately reflected his smoking status.2. The facility failed to ensure Resident #68's quarterly MDS, dated [DATE], accurately reflected her smoking status. 3. The facility failed to ensure Resident #93's quarterly MDS, dated [DATE], accurately reflected her smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment for smoking status. Findings include: 1. Record review of Resident #48's face sheet, dated 08/20/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #48 had a diagnosis which included hemiplegia (paralysis and weakness on one side of the body that can affect the arms, legs, and facial muscles). Record review of Resident #48's admission MDS, dated [DATE], revealed Resident #48 had a BIMS of 14, which indicated intact cognitive response. The MDS also revealed current tobacco use was not checked. Record review of Resident #48's care plan, dated 8/14/2025, revealed Resident #48 was a smoker. The goal in place was the resident will not suffer injury from unsafe smoking practices through the review. Interventions were instructing resident about smoking risks and hazards and about smoking cessation aids that were available. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Smoking assessment per facility Policy. Record review of Resident #48's Smoking Assessment, dated 8/15/2025, revealed Resident #48 required partial physical assistance with mobility and supervision during smoke break. 2. Record review of Resident #68's face sheet, dated 08/19/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #68 had diagnoses which included cerebral infraction (stroke), major depressive disorder (mental health disorder characterized by persistent depressed mood), lack of coordination, viral hepatitis C (a bloodborne virus that causes liver inflammation), Parkinson's disease (a progressive disorder that affects the nervous system), anxiety (feeling of uneasiness or worry), muscle weakness and morbid obesity. Record review of Resident #68's quarterly MDS, dated [DATE], revealed Resident #68 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed current tobacco use was not on the MDS. Record review of Resident #68's care plan, dated 07/29/2025, revealed Resident #68 did not have her smoking status on the care plan. Record review of Resident #68's Smoking Assessment, dated 06/02/2025, revealed Resident #68 required supervision and one-on-one assistance. The resident needed to be supervised due to contractions. 3. Record review of Resident #93's face sheet, dated 08/20/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #93 had diagnoses which included lack of coordination, anemia (not enough healthy red blood cells), Schizophrenia (mental disorder that affects a person's ability to think, feel and behave clearly), bipolar (extreme mood swings), anxiety (feeling of uneasiness or worry), depressive disorder (mental health disorder characterized by persistent depressed mood), hypertension (high blood pressure), insomnia (difficulty sleeping), muscle wasting, muscle weakness, and lack of coordination. Record review of Resident #93's admission MDS, dated [DATE], revealed Resident #93 had a BIMS of 15, which included intact cognitive response. The MDS also revealed current tobacco use was not checked on the MDS. Record review of Resident #93's care plan, dated 08/14/2025, revealed Resident #93 did not have her smoking status on the care plan. Record review of Resident #93's Smoking Assessment, dated 08/17/2025, revealed Resident #93 required supervision when smoking. The resident could light her own cigarette, but the facility would follow policy and have the resident supervised. During an interview with the MDSN on 08/21/2025 at 2:02 p.m., revealed she was trained on the MDS but not at the facility. She said the IDT was responsible for the MDS, but she completed most of the MDS's. She said information that was on the MDS were assessments, pain, and data collection from a resident's medical records. She said the MDS should be updated when there was a significate change, or a regulatory requirement. She said she had fourteen days from admission to complete the MDS. She said there was a question on the MDS about the resident's tobacco use and if the resident were a smoker, it would be checked yes. She said if the resident's smoking status were not coded correctly it would not get addressed. She said staff may not know who needs supervision. She said she was never told who smokers were did not answer why she did not know. She said the reason Resident #48, Resident #68, and Resident #93's smoking status was not on the MDS, was because she did not know who the smokers were. She also

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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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 0645 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 interview and record review, the facility failed to ensure a new resident was not admitted with mental illness unless the state mental health authority determined, based on independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission for 1 of 12 residents (Resident #17) reviewed for PASRR services. The facility failed to ensure a PASRR screening was completed for Resident #17. This deficient practice could place residents at risk for not obtaining the services needed to treat their mental health diagnoses.The findings include: Record review of Resident #17's admission sheet, dated 08/19/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included cystitis without hematuria (inflammation of the bladder), somatization disorder (tendency to experience and express psychological distress as physical symptoms), fusion of the spine (surgical procedure that connect two or more parts in the spine), muscle weakness, congenital malformation of nervous system (birth defect that affects the structure and development of the brain and spinal cord), lack of coordination, anxiety disorder (feeling of uneasiness or worry) and hypertension (high blood pressure). Record review of Resident #17's admission MDS assessment, dated 06/23/2025, revealed Resident #17 had a BIMS score of 13, which indicated intact cognitive response. Resident #17's mood indicators were present which included little interest or pleasure in doing things, feeling down, depressed, or hopeless. The MDS also documented somatization disorder (tendency to experience and express psychological distress as physical symptoms), and anxiety disorder (feeling of uneasiness or worry) as active diagnoses. Record review of Resident #17's care plan, dated on 07/01/2025, noted the resident used an anti-anxiety medication r/t anxiety. The goal was Resident #17 would be free from discomfort or adverse reactions related to anti-anxiety therapy. The interventions were Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucination. Record review revealed Resident #17 did not have a PASRR completed. During an interview with Resident #17 on 08/21/2025 at 11:02 a.m., Resident #17 said she was diagnosed with her mental disorders when she was [AGE] years old. She said she was taking anxiety medication. She said the only other service she was getting for her mental illness was seeing the psychiatrist. She said she did not know if there were other services she might want. During an interview with Marketing on 08/21/2025 at 11:30 p.m. revealed she had not been completely trained on PASRR. She said she was responsible for making sure the resident had a PASRR when they entered the facility. She said the only training she got on PASRR was the PASRR needed to be filled out. She said she could not answer the question of the process, or referrals. She also said she did not know when the PASRR should be done. She said all she knew was the resident needed a PASRR when the resident admitted to the facility for skilled. She said she did not know she needed a PASRR for long term care. She said she was confused on that part. She said she did not know what to do if a resident had a positive PASRR. She said her job was to go out and educate the community about the facility's services. She said when a referral came in, she would send an email the nursing team with the resident's clinical records. She said she did not know what could happen to the residents if they did not have a PASRR. She said she did not know why Resident #17 did not have the PASRR on admission. During an interview with the SW on 08/21/2025 at 2:38 p.m. revealed she had not been trained on PASRR. She also said she did not have anything to do with the PASRR's. During an interview with the MDSN on 08/21/2025 at 2:20 p.m. revealed she was trained on PASRR. She said she did not know what the policy was for PASRR. She said she knew she must have a PASRR before a resident was admitted . She also said if the resident was coming from the community a PASRR needed to be done prior to admission. She said marketing was responsible for ensuring each resident had a PASRR prior to admission. She also said she would ask for the PASRR level one to see if the resident had a qualifying diagnosis. She said if the resident had a qualifying diagnosis, she would submit to the portal so the mental health case worker could come do an assessment on the resident. She said the purpose of the PASRR was to make sure the resident got the services they required and were in the least restrictive environment. She said the facility would have an IDT

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 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 interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for one of three residents (Resident # 29) reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission for Resident #29. This failure could place residents at risk for not receiving care and services to meet their needs. Findings include: Record review of Resident #29's face sheet, dated 08/21/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #29 had diagnoses which included tracheostomy status (a resident's condition of having a surgically created opening in their windpipe with a tube inserted to help them breathe), nontraumatic intracerebral hemorrhage, unspecified (bleeding within the brain tissue that is not caused by a physical injury or trauma), and unspecified convulsions (involuntary spasms and contractions). Record review of Resident#29's admission MDS Assessment, dated 08/13/2025, reflected it was in progress. Record review of Resident #29's Baseline Care Plan, dated 08/07/2025, reflected the following sections were not completed: therapy services- physical therapy, occupational therapy, speech therapy, restorative therapy (the comment section under therapy was blank), and social services: social service provided, mental health needs, behavioral concerns, PASARR Level II (a comprehensive assessment conducted after a positive Level I screening in the Preadmission Screening and Resident Review process) recommendations, social service goals, and depression screening. The section where the resident's preference for being notified of updates to Plan of Care was blank. The signature of the resident and Representative were not obtained for the baseline care plan. Signed by: Treatment Nurse. Interview on 08/21/2025 at 1:30 PM, the Administrator stated she expected the baseline care plan to be completed including the section on therapy and social services. She stated it was important for the staff to know any interventions needed if a resident had behaviors. She stated if a resident had triggers such as using certain words the staff would need to know this to prevent the resident from having anxiety or depression. She stated she expected the baseline care plan to be signed by the resident or family. The administrator stated therapy information needed to be documented on the baseline care plan and if the resident did not need therapy the staff was expected to document this information in the comment section. The Administrator stated the nurse supervisor who received the resident upon admission was responsible to begin the baseline care plan and it was to be completed within 48 hours upon admission date. She stated the DON, or the Treatment Nurse was responsible to review the baseline care plan after completion to ensure accuracy and completion within 48 hours. Interview on 08/21/2025 at 1:59 PM, the MDSN stated the charge nurse was responsible for the new admission and was in charge of completing the baseline care plan. She stated all the baseline care plans were to be completed in its entirety within 48 hours of the resident's admission date. The MDSN stated the social service section needed to be completed especially if a resident had any type of emotional or psychosocial needs the staff needed to be aware of to give care to the resident. She stated if a resident needed to be assessed by therapy the nurse completing the baseline care plan was expected to document this information within 48 hours of the admission date. Interview on 08/21/2025 at 2:24 PM, the Treatment Nurse, RN stated she did assess Resident # 29 upon admission. She stated she completed Resident #29's baseline care plan. She stated the social service section was vital information to provide to the staff. The Treatment Nurse, RN stated if a resident had any type of behaviors and needed special interventions the staff would not know how to care for the resident if the resident exhibited behaviors. She also stated a resident may have PTSD (post-traumatic stress disorder) and the staff would need to know the residents' triggers to prevent any type of anxiety or depression. The Treatment Nurse stated the resident, or family was expected to sign the baseline care plan, and she did not review the baseline care plan with Resident #29's family or with Resident #29. She stated therapy information was expected to be documented on the baseline care plan to ensure the staff knew the resident would need to be assessed by therapy. She stated she did not recall the reason she did an incomplete baseline care plan on Resident #29. The Treatment Nurse stated it was her responsibility or the Director of Nurses responsibility to ensure all the baseline care plans were completed. She stated all baseline care plans were to be completed within 48 hours of the admission date. She stated if a charge nurse completed the baseline care plan, either she or the Director of Nurses would review the baseline care plan to ensure it was completed and accurate within 48

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 8 of 16 (Resident #7, Resident #10, Resident #17, Resident #21 Resident #31, Resident #65, Resident #68 and Resident #86) reviewed for care plans. 1. The facility failed to ensure Resident #7's comprehensive care plan was updated after the code status was changed from full code to DNR on [DATE]. 2. The facility failed to ensure Resident # 10, Resident #17 and Resident #21's comprehensive care plan was updated with Resident #10, Resident #17, and Resident #21's in room activity needs. 3. The facility failed to ensure Resident #31's comprehensive care plan was updated with Resident #31's advance directive when the care plan was completed on [DATE].4. The facility failed to ensure Resident #65 and Resident #86's comprehensive care plan was updated to include contact isolation.5. The facility failed to ensure Resident #68's comprehensive care plan was updated with her smoking status when the care plan was completed on [DATE]. This deficient practice could place residents at risk of not being provided with the necessary care or services and the implementation of personalized plan of care developed to address their specific needs. The findings include: 1. Record review of Resident #7's face sheet, dated [DATE], revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke), muscle weakness, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), lack of coordination, adjustment disorder, hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), repeated falls, cerebral infraction (long term effects of a stroke), and protein-calorie malnutrition (inadequate intake of both protein and calories). Record review of Resident #7's quarterly MDS, dated [DATE], revealed Resident #7 had a BIMS of 08, which indicated moderate impairment. The MDS did not document Resident #7's code status. Record review of Resident #7's care plan, dated [DATE], revealed Resident #7 was a full code. The Goal was Resident #7 would be provided with necessary resuscitative measures. Interventions were to advise MD, RP & family of any changes in condition per facility policy. Educate and discuss with resident/family about Full Code status versus OOHDNR code status on an annual basis or as needed. Review Advanced Directives with resident/family annually, upon change in condition andas needed. Record review of Resident #7's Advance Directive Order, dated [DATE], revealed Resident #7 was a DNR. Record review of Resident #7's OOHDNR, dated [DATE], had all the required signatures (doctor signature, RP signature and witness signatures). 2. Record review of Resident #10's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident#10 had a diagnosis which included depression (when a person experiences a persistent sad mood), cognitive communication deficit (communication skills that results from impaired memory, attention, reasoning, and problem-solving which are necessary for effective communication), and generalized anxiety disorder (excessive, persistent, and unrealistic worry about everyday things). Record review of Resident#10's admission MDS Assessment, dated [DATE], reflected Resident #10 had a BIMS score of 15, which indicated her cognition was intact. The following activities were very important to Resident #10: reading, music, being around animals, keep up with the news, going outside for fresh air and participating in religious practices. Record review of Resident#10's Comprehensive Care Plan, revised on [DATE], did not reflect Resident #10's activity plan. 3. Record review of Resident #17's face sheet, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had a diagnosis which included somatization disorder (a mental health condition characterized by excessive focus on physical symptoms, causing significant distress and functional impairment. Intense worry and preoccupation with these symptoms), congenital malformation of nervous system, unspecified (a birth defect affecting the structure or function of the brain, spinal cord, or other parts of the nervous system, but the specific type of malformation is not known), and anxiety disorder (a mental health condition characterized by excessive and persistent fear, worry or tension that interferes with daily life causing distress). Record review of Resident #17's admission MDS Assessment, dated [DATE], reflected Resident #15 had a BIMS score of 13, which indicated her cognition was intact. The following activities were important to Resident#17: listening to music, being around

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	675118	A. Building B. Wing	08/21/2025

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

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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 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)

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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 interview and record review the facility failed to ensure comprehensive care plans were developed within 7 days after completion of the comprehensive assessment for 2 of 7 residents (Resident #78 and Resident #37) reviewed for comprehensive assessments and timing. 1. The facility failed to ensure Resident #78's Comprehensive Care Plan was completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission. 2. The facility failed to ensure Resident #37's Comprehensive Care Plan was completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission. These failures could place residents at risk for not receiving necessary care and services or having important care needs identified and met.The findings include: 1. Record review of Resident #78's admission record, dated 08/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #78 had diagnoses which included Parkinson's disease (a progressive disorder that affects the nervous system), lack of coordination, muscle weakness, cognitive communication deficit (problems with communication), dementia (memory, thinking, difficulty), hypertensive heart disease (damage to heart due to chronic high blood pressure), depression, and anxiety (feeling of uneasiness or worry). Record review of Resident #78's care plan, undated and last revised 04/01/2025 reflected there was no information regarding self-care and requiring substantial/maximal assistance with putting on/taking off footwear. Record review of Resident #78's Nursing Home Part A PPS Discharge (NPE) MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderate impairment. Further review of the MDS reflected the resident required substantial/maximal assistance with putting on/taking off footwear. Record review of Resident #78's care plan dashboard, dated 08/21/2025, reflected the care plan was generated for start date of 08/28/2025 with a target completion date of 09/10/2025. 2. Record review of Resident #37's admission record, dated 08/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #37 had diagnoses which included local infection of the skin, chronic kidney disease stage 4 (a serious condition where the kidneys are severely damaged), anemia (not enough healthy red blood cells), irritable bowel syndrome (a group of symptoms that occur together including repeated pain in your abdomen and changes in your bowel movements), and muscle weakness. Record review of Resident #37's admission assessment MDS, dated [DATE], reflected a BIMS score of 14, which indicated cognition was intact. Record review of Resident #37's initial baseline care plan, undated with date initiated 07/10/2025 and last revised 08/19/2025, reflected only one goal and need was implemented for Resident #37's care plan, actual falls. All other needs and goals for Resident #37 were implemented on the care plan on 08/19/2025, which included: full code status, limited physical mobility and requires staff assistance for ADLs, congestive heart failure, altered cardiovascular status, anemia due to chronic blood loss, on antibiotic therapy, potential unintentional weight loss/gain, risk for skin breakdown and pressure ulcer development due to decreased mobility, has occasional bowel and bladder incontinence, and has impaired visual function. During an interview on 08/21/2025 at 2:09 PM, the MDSN stated she did not know the last time she had training regarding care plans. She stated the IDT meeting was opened by the RN and completed the bulk of the care plans. She stated she reviewed the cause section B on the MDS and completed a chart sweep looking for special medication or diagnosis or high-risk medications, followed by a review of progress notes to get family dynamics and would care plan falls, pain, based on this information. She stated the charge nurses had 48 hours to complete the base line care plans, and she had 7 days after to complete the comprehensive care plans. She stated care plans were updated when there was any change to the resident's care, as needed or when the MDS was due. Depending on what needed to be updated on a care plan depended on which staff was responsible for completing. She said she did not know why Resident #78 and Resident #37 care plans were completed. During an interview on 08/21/2025 at 3:50 PM, the ADM stated she last received basic care plan training in January 2025. She stated training covered patient center care, the goal and discharge plan. She stated the IDT team, MDS, therapy, and nursing staff were all responsible for completing the care plans. She stated the baseline care plan was to be completed within 24 hours and comprehensive care plan was due 7 days after. She stated the care plan should be updated quarterly or if there was a significant event. During an interview on 08/21/2025 at 4:17 PM, the DON stated she was knowledgeable of completing care plans from PCC. She stated the RN opened the care plan, the MDS Coordinator followed up and the DON reviewed the care plan

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 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, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 12 residents (Resident #38) reviewed for Activities of Daily Living. The facility failed to ensure Resident #38 was provided her showers 3 times a week as scheduled. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings include: Record review of Resident #38's admission record, dated 08/21/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #38 had diagnoses which included hypertensive heart disease without heart failure (changes in the heart due to long term high blood pressure), hyperlipidemia (abnormally high level of fats in the blood), depression (a mood disorder with persistent feeling of sadness and loss of interest), and generalized muscle weakness. Record review of Resident #38's Quarterly MDS, dated [DATE], reflected a BIMS score of 13, which indicated cognition was intact. Section GG - Functional Abilities reflected Resident #38 required Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for showers/bathing self. Record review of Resident #38's care plan, dated 09/16/2022 and last revised 12/02/2024, reflected the following I have an ADL self-care performance deficit r/t decline in cognition. Interventions reflected Personal Hygiene: I require assistance by 1 staff with personal hygiene and oral care. Record review of the, undated, shower schedule reflected the room/bed Resident #38 occupied on 08/21/2025 was scheduled for a shower on Tuesday/Thursday/Saturday. Record review of the task list in the electronic health record for the dates 07/22/2025-08/21/2025 reflected she was scheduled for ADL - Bathing (T-TH-Sat 6p to 6a). She was provided the following showers:07/24/2025,07/29/2025, 08/12/2025, 08/19/2025, and08/21/2025. Showers were scheduled but not documented as given on:07/22/2025,07/26/2025, 07/31/2025, 08/02/2025, 08/05/2025, 08/07/2025 (documented as refused), 08/09/2025, 08/14/2025, and08/16/2025 (documented as refused). Record review of Resident #38's nurses' notes, dated 07/22/2025-08/22/2025, reflected no documentation of refusal of care. Interview and observation on 08/19/2025 at 09:41 AM, Resident #38 stated she had not received a shower in weeks. Resident #38 appeared clean and well-groomed. Interview and observation on 08/21/2025 at 08:10 AM revealed Resident #38 propelled herself in her wheelchair, her hair was standing up in the back and appeared not brushed. Resident #38 stated she had not received her shower in 4 weeks. She stated she was unsure of her shower day, just that they [the staff] would come at night around 09:30 PM to give her a shower and she did not want to go to bed with her hair wet, so she refused. Interview on 08/21/2025 at 03:55 PM, CNA J stated he was working the hallway Resident #38 resided on. He stated he typically did not work the floor and was unable to access the electronic health record. CNA J stated Resident #38 was supposed to get showers in the morning despite her bed assignment. He stated the staff should know though shift report, but he did not know if it was documented anywhere. CNA J stated if a resident refused a shower, then the CNA should notify the nurse. He stated Resident #38 should get 3 showers a week. He stated if a resident did not get their showers, then the resident could become sad, embarrassed, and dirty. Interview on 08/21/2025 at 04:15 PM, CNA H stated she was responsible for the hallway Resident #38 resided on. She stated showers were given per the residents' room assignment. She stated if a resident wanted a different schedule for their showers, then the CNA was responsible for reporting it to the nurse and the nurse would fix the schedule in the computer. CNA H stated if a resident refused a shower, then the CNA was responsible for reporting it to the nurse and completing a shower sheet that indicated the resident refused the shower. She stated she gave Resident #38 a shower during the day shifts a couple of weeks ago, but Resident #38 was scheduled for evening showers. CNA H stated all residents should be getting a shower three times a week. She stated if a resident did not get their shower, then they may feel sad or dirty. Interview on 08/21/2025 at 04:49 PM, the TN stated she was appointed to monitor shower sheets on 08/18/2025. She stated the policy for giving showers was three times a week and the CNAs were to follow the schedule on the handout. She stated if a resident wanted a shower other than what was listed on the handout then it should be documented in their electronic health record. The TN stated, if a resident were to refuse a shower, she expected the CNA to notify the nurse and the nurse to attempt to get the resident to take a shower. She stated if the resident continued to refuse then she expected the nurses to document the refusal in the

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed, to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three of six residents (Resident #10, Resident #17, and Resident #21) reviewed for activities. The facility failed to provide Resident # 3, Resident #10, Resident #17, and Resident #21 in room activities during July 2025 and August 1st thru August 22, 2025.This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings include:Record review of Resident #10's face sheet, dated 08/21/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10 had diagnoses which included depression (when a person experiences a persistent sad mood), cognitive communication deficit (communication skills that results from impaired memory, attention, reasoning, and problem-solving which are necessary for effective communication), and generalized anxiety disorder (excessive, persistent, and unrealistic worry about everyday things). Record review of Resident#10's admission MDS Assessment, dated 05/19/2025, reflected Resident #10 had a BIMS score of 15, which indicated her cognition was intact. The following activities were very important to Resident #10: reading, music, being around animals, keep up with the news, going outside for fresh air and participating in religious practices. Record review of Resident#10's Comprehensive Care Plan, revised on 08/28/2025 did not reflect Resident #10's activity plan. Record review of Resident #17's face sheet, dated 08/21/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included somatization disorder (a mental health condition characterized by excessive focus on physical symptoms, causing significant distress and functional impairment. Intense worry and preoccupation with these symptoms), congenital malformation of nervous system, unspecified (a birth defect affecting the structure or function of the brain, spinal cord, or other parts of the nervous system, but the specific type of malformation is not known), and anxiety disorder (a mental health condition characterized by excessive and persistent fear, worry or tension that interferes with daily life causing distress). Record review of Resident #17's admission MDS Assessment, dated 06/23/2025, reflected Resident #17 had a BIMS score of 13 which indicated her cognition was intact. The following activities were very important to Resident#17: listening to music, being around animals, keep up with the news, go outside when the weather was good and participate in religious services and practices. Record review of Resident #17's Comprehensive Care Plan, dated 07/01/2025 reflected Resident current activity plan was not documented. Record review of Resident # 21's face sheet, dated 8/21/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #21 had diagnoses which included cognitive communication deficit (communication skills that results from impaired memory, attention, reasoning, and problem-solving which are necessary for effective communication), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (it is a group of symptoms that can affect thinking, memory, and reasoning without behaviors), and adult failure to thrive (a syndrome of general decline in an older adult's physical and functional capabilities, marked by symptoms like weight loss, poor appetite, and decrease in physical activity). Record review of Resident #21's admission MDS Assessment, dated 04/24/2025, reflected Resident #21 had a BIMS score of 15, which indicated her cognition was intact. The following activities were very important to Resident #21: reading, listen to music, being around animals, keep up with the news, going outside to get fresh air when weather permits. Record review of Resident #21's Quarterly MDS Assessment, dated 07/25/2025, reflected Resident #21 had a BIMS score of 11, which indicated her cognition was moderately impaired. Record review of Resident #21's Comprehensive Care Plan, dated 08/08/2025 reflected Resident #21 did not have an activity care plan. Record review of in room activity participation records, dated July 2025 and August 1, 2025, thru August 22, 2025, reflected Resident # 10, Resident #17 and Resident #21 did not receive in room activities. Record review of residents to receive in room activities for the month of July 2025 and August 2025 reflected Resident #10, Resident #17, and Resident #21 names were on the in-room record. During an interview with Resident #17 on 08/19/2025 at 10:27 AM, revealed that she does not get any activities. She said staff do not give her any books, puzzles, or anything else. She said

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment for 4 (Residents #17, #37, #3, and #73) of 20 residents reviewed for sufficient staffing. The facility failed to ensure that the facility had sufficient staffing to meet the needs of Residents #17, #37, #3, and #73. This failure could affect and diminish the resident's quality of life by potentially placing the residents at risk of not receiving timely care or receiving nursing interventions to meet the resident's needs, risk of injury, risk of safety, and/or it can make the resident feel neglected affecting their mental health and overall psychosocial well-being not being met by facility staff.Findings include: Record review of Resident #17's admission record, dated 08/21/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included acute cystitis without hematuria (inflammation of the bladder), other benign neoplasm of uterus (noncancerous tumor in women and people assigned female at birth), somatization disorder (mental health condition characterized by significant distress and impairment related to physical symptoms that may not have a clear medical explanation), fusion of spine, muscle weakness, congenital malformation of nervous system (birth defects that affect the structure and function of the brain and spinal cord), lack of coordination, anxiety disorder, and aftercare following joint replacement surgery. Record review of Resident #17 admission MDS, dated [DATE], reflected a BIMS score of 13, which indicated cognition was intact. Section GG - Functional Abilities reflected Resident #17 required Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene and chair/bed-to-chair transfer. Record review of Resident #17's care plan, dated 06/20/2025, reflected the following clean peri-area with each incontinence episode. Record review of Resident #37's admission record, dated 08/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #37 had diagnoses which included local infection of the skin and subcutaneous tissue, chronic kidney disease, stage 4 (severe), iron deficiency anemia, irritable bowel syndrome, and muscle weakness. Record review of Resident #37's admission MDS, dated [DATE], reflected a BIMS score of 14, which indicated cognition was intact. Section GG - Functional Abilities reflected Resident #37 Needed Some Help - Resident needed partial assistance from another person to complete any activities for self-care and Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for showers/bathing self. Record review of Resident #37's initial baseline care plan, undated with date initiated 07/10/2025 and last revised 08/19/2025 reflected the following, Resident #37 has limited physical mobility and requires staff assistance for ADLs. Interventions reflected Provide supportive care, assistance with mobility as needed. Further review of Resident #37's initial baseline care plan reflected the following, Resident #37 has occasional bowel and bladder incontinence r/t impaired mobility and IBS (common condition that affects the stomach and intestines). Interventions reflected Clean peri-area with each incontinence episode. Record review of Resident #3's admission record, dated 08/20/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with readmission on [DATE]. Resident #3 had diagnoses which included chronic obstructive pulmonary disease, unsteadiness on feet, cognitive communication deficit, pain in right shoulder, mild cognitive impairment, difficulty in walking, major depressive disorder, insomnia, muscle weakness, heart failure, sleep apnea, morbid obesity. Record review of Resident #3's Quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated cognition was intact. Section GG0115. Functional Limitation in Range of Motion reflected Resident #3 required Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half.the effort for toileting hygiene. Record review of Resident #3's care plan, dated 04/27/2021 and last revised 02/14/2025, reflected the following I have an ADL self-care performance deficit r/t lack of safety awareness and muscle weakness. Interventions reflected TOILET USE: requires assistance by (1) staff for toileting. Record review of Resident #73's admission record, dated 08/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #73 had diagnoses which included other sequelae of cerebral infarction (condition of brain swelling, blood clots, trouble swallowing, pneumonia, bladder and

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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. (continued on next page)

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F 0761 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 observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments, under proper temperature controls, and labeled in accordance with currently accepted professional principles for 1 of 1 medication storage room refrigerator and 1 of 3 (200 hall) medication carts reviewed for medication storage. 1. The facility failed to ensure the 200-hall medication cart was locked and medications were secured and not accessible to other staff, residents, or visitors. 2. The facility failed to ensure the refrigerator maintained the adequate temperature to store medications (35 - 40 degrees Fahrenheit) that required refrigeration prior to opening. These failures could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missed medications.Findings included: Observation on 08/20/2025 at 9:08 AM revealed an unlocked medication cart beside room [ROOM NUMBER]. The medication cart was between room [ROOM NUMBER] and room [ROOM NUMBER]. The front of the medication cart was facing toward the end of the hall. The locking mechanism was protruding outward on the medication cart. The state surveyor opened drawers and captured pictures. RN D was in room [ROOM NUMBER] with the door closed. Observation on 08/20/2025 at 9:12 AM RN D exited room [ROOM NUMBER] and went to the unlocked medication cart. Interview on 08/20/2025 at 9:14 AM RN D stated the medication cart was to always be locked except when he was dispensing medications from the medication cart. He stated it was his responsibility to ensure the medication cart was locked and secure. RN D stated the key to the medication cart was in his pocket. He stated if residents had accessed the medication cart they could have overdosed, taken wrong medication, had an allergic reaction, and could require admission to the hospital. He stated he had previously been in-serviced on locking the medication carts and could not recall the specific date. He stated he was aware the medication cart should have been locked. He stated the narcotics were locked and were not accessible. RN D stated there was PRN medications and some medical equipment such as blood pressure and glucometer that were not locked. Interview on 08/20/2025 at 9:30 AM the DON stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The DON stated she did not know the exact date of the in-service. She stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. She stated if a resident ingested medications not prescribed to them, there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. She stated it was the nurse's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. The DON stated she was responsible for monitoring the nurse supervisor. Interview on 08/22/2025 at 1:30 PM the ADM stated her expectations was for the medication carts to be locked when the nurses were not administering medications from the carts. She stated there was a possibility a resident may get medications out of the medication cart. The ADM stated if a resident did take the medications by mouth there was a possibility a resident may have an allergic reaction. She stated it depended on the medication the resident ingested. She stated the nurse assigned to the medication cart was responsible for locking the medication cart after administering medications to a resident. The ADM stated the DON was responsible to monitor the nurse supervisor. Observation and interview on 08/21/2025 at 10:14 AM in the medication storage room with the TN revealed the one medication storage refrigerator with 2 thermometers sitting on the top shelf, one thermometer read 51 degrees, and the other thermometer read 47.5 degrees. The log on the refrigerator door did not have a reading for that day, at the bottom of the log page was handwritten Refrigerator temp 35 F - 40 F. The TN stated the temperature in the refrigerator should be lower and turned the dial inside the refrigerator to adjust the temperature. The medication refrigerator contained multiple medications including: Lantus Solostar (an insulin for diabetes), Insulin Lispro, Insulin Glargine, Wegovy (a medication used for diabetes or weight loss), Humulin 70/30 Kwikpen (an insulin for diabetes), Trulicity (a medication used for diabetes), Acetaminophen suppositories (a medication used for fever and pain when medication cannot be taken by mouth), Glycerin suppositories (a medication used for constipation), Bisacodyl Suppositories (a medication used for constipation), Brimonidine-Timolol (an eye drop used to decrease eye pressure), Latanoprost (an eye drop used to decrease eye pressure), a vaccine for the respiratory syncytial virus (a common respiratory virus that is highly contagious), and Acidophilus (a probiotic). The refrigerator was not at correct temperature. Observation on 08/21/2025 at 10:28 AM revealed the medication storage room one of

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	675118	A. Building B. Wing	08/21/2025

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and attractive and prepare food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed. 1. The two test tray for lunch meal included foods that were bland, and unappealing. 2. The lunch meal trays being delivered to 300 hall residents were unappealing with small side portions. 3. The meal delivery cart doors left open during delivery of hallway meals and reducing the food temperatures. 4. Watery and mushy vegetables served to residents on 08/20/2025. These failures could place residents at risk of decreased food intake, hungry, unwanted weight loss, and diminished quality of life. Findings included: Observation on 08/19/2025 at 12:00 PM revealed unappealing meal trays with poor arrangement of food and small portions of okra being delivered to hallway 300.Food test tray #1 was received at 12:29 PM on 08/19/2025 and was well-presented and arrangement of food was appealing. The tray contained a large white serving plate with an adequate portion of fried okra placed in a small bowl for appearance, corn bread, chili with beans was arranged in a bowl, 2 portions of shredded cheese, donut holes, tea, water, salt, pepper, butter, and utensils wrapped in napkin.Observation and interview on 08/20/2025 at 11:15 AM revealed the broccoli was sitting in a large steal pan filled with water. CK L was observed monitoring food temperatures and stated the broccoli and water remain in the deep pan until meal service and it is drained before serving. Observation on 08/20/2025 at 11:42 AM revealed CDM instructing CK M to drain out as much water from the steal pan of broccoli. CK M used a perforated portion spoon to remove water from the broccoli pan in a slow pace. He was then instructed to stop and to drain as much water when portioning on plate. Broccoli was served on resident plates.Observation on 08/20/2025 at 12:15 PM revealed the meal delivery cart transporting resident meals to hallway 100 was left wide open. The meal delivery cart doors were left open for several minutes exposing resident meal trays and reducing the food temperatures.Food test tray #2 was received at 1:03 PM on 08/20/2025 and the boiled broccoli was mushy and watery. Surveyor tested the tray, and the broccoli was overcooked, soft and squashy, without any seasoning, and dull. The food was warm. During an interview on 08/21/2025 at 10:00 AM, ADM stated the CDM was responsible for maintaining hot, appealing, and flavorful food. She stated she had not heard of complaints regarding food and would ensure the DM was aware of complaints and working with the dietician to improve meals. During an interview on 08/21/2025 at 3:57 PM, CK L stated that vegetables should not sit in water until they were served. She stated she does not leave water in her vegetables and will drain them. She stated if the vegetables remained in water for too long, she would throw it away, because they become mushy. CK L stated this is not the common practice in the kitchen; however, CK M is a new cook in training, and she is trying to teach him good practices as she knows the residents do not like mushy and flavorless foods and would complain about it. CK L stated she hears a lot of complaints when other cooks prepare food as there is no flavor, and limited seasoning of only salt and pepper is used. She stated residents want meals to look forward to. CK L stated using the correct measuring scoops and spoons for serving is necessary for residents to maintain weight and nutrition. She stated following recipes and seasoning required is necessary for meals to be flavorful.During an interview on 08/21/2025 at 4:18 PM, CDM stated she has received complaints from the resident council regarding food being served cold. She stated she believes food may be cold if not delivered to table immediately or to the resident's room in a reasonable time. She stated she does not understand why food becomes cold quickly but will look into this. She stated the broccoli left in water should have been drained before putting the tray on the serving steam table. She stated she was distracted with training a new cook that she overlooked the broccoli staying in water too long and becoming mushy. She stated vegetables are the last food cooked for any meal as they require less time. She stated residents receiving unflavored and mushy vegetables could affect the resident by reducing their nutrition as they may not eat. CDM stated cooks are expected to use the correct portion sized serving tools when serving plates as anything less could affect the residents with weight loss. She stated that all plates served either in the dining room or in the resident rooms should all be uniformed and be appealing so the resident will want to eat it.Review of facility policy undated, titled Food and Nutrition Services revealed Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 6. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, interviews, and record review the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen and the facility's only nourishment room reviewed for food and nutrition services. 1. The facility failed to label and date food items in the only walk-in refrigerator. 2. The facility failed to label and date food items in the only nourishment refrigerator.3. The facility failed to maintain the proper temperature of the refrigerator in the nourishment room.4. The facility failed to ensure that the walk-in freezer was maintained at acceptable temperatures which resulted in frozen foods thawing out and then re-freezing without being discarded. 5. The facility failed to ensure that foods were stored away from leaks of malfunctioning cooling fans in the walk-in refrigerator. 6. The facility failed to ensure food products are discarded on or before the expiration date. 7. The facility failed to maintain temperature logs to monitor the nourishment refrigerator to ensure that it is functioning properly. These failures could place residents at risk for health complications, weight loss, foodborne illnesses, and decreased quality of life. Findings include: Observation and interview on 08/19/2025 at 4:30 PM revealed a large metal tray containing opened cooked ham with lid and label of prepared date 08/10/2025 and use by date 08/17/2025 stored in the walk-in refrigerator. The CDM stated the discard date for this food item should be within 7 days of prepared date. She stated it was now 9 days after prepared date and should not be in the refrigerator. She was observed removing the metal tray from the refrigerator to discard food item. Observation on 08/19/2025 at 4:37 PM revealed the walk-in freezer thermometer panel mount temperature was reading 3 . Observation on 08/20/2025 at 10:59 AM revealed the walk-in freezer thermometer panel mount temperature was reading 3 . Observation and interview on 08/20/2025 at 11:00 AM revealed a slow steady water leak from the bottom of the refrigerator cooling fans dripping into a large black plastic bin positioned directly underneath. CDM stated this was a new leak that has been reported to the maintenance staff for immediate repairs. She stated the black plastic bin is to keep the water from leaking onto the food stored on the shelf. She stated all packaged food was removed from this shelf temporarily awaiting repairs. She stated she believes the walk-in freezer temperature is above 0 as staff have been in and out of it this morning prepping foods for the day and organizing frozen foods. Observation on 08/20/2025 at 11:33 AM revealed salad plates with plastic wrap and plastic salad bowls with lids unlabeled and undated in the walk-in refrigerator. CDM immediately grabbed food items and went to add labels to them. During an interview on 08/20/2025 at 1:13 PM, MAIN stated kitchen work orders are handled by him and one other staff. He stated he will reach out to 3rd party contractors if unable to make a repair himself, such as the walk-in refrigerator and walk-in freezer. He stated the leak was reported to him last week some time, the refrigeration contractor visited the facility last week to look at it. He stated there was a delivery last week and staff had the refrigeration doors open, and a lot of condensation was building up when the contractor was assessing. He stated the contractor recommended for him to look at adding some fans to the refrigerator, so it does not create condensation. He stated he also believed since the freezer doors were open for delivery it caused the temperature to rise. He stated kitchen staff are emptying the black plastic bin during morning and night shifts. He stated he has been researching how to run fans for the condensation build up, and he will have to put in an electrical system to install the fans. He stated it would be best if he looked at the inside of the refrigerator, not draining, not sure about the water build up, and look at air curtains for the doors. He stated he has requested invoices and estimates for this work. MAIN stated if water were to leak onto the stored food, staff should not use it as this could affect the residents and make them sick. Surveyor requested work orders submitted for temperatures and water leak concerns, invoices, and estimates from contractors regarding recommendations and repairs and recommended plan to repair the refrigeration systems. These items were not provided prior to exit. Observation on 08/21/2025 at 9:00 AM revealed the walk-in freezer thermometer panel mount temperature was reading 15 and the 2 dial freezer thermometer located in the walk-in freezer was reading 30 . Observation on 08/21/2025 at 9:07 AM revealed the walk-in freezer thermometer panel mount temperature was reading 15 and the 2 dial freezer thermometer located in the walk-in freezer was reading 18 . Observation and interview on 08/21/2025 at 9:11 AM revealed the large black plastic bin positioned directly underneath the cooling fans in the walk-in refrigerator was filled with dirty water that has leaked into it. CDM stated the black bin fills throughout the day and is dumped out every morning and evening shift. She removed the plastic bin to drain water, and the piping of the refrigerator was exposed and had rust and black tape wrapped around the hinges. Observation and interview on 08/21/2025 at 9:12 AM

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 4 of 6 residents (Resident #29, #65, #70 and #86) reviewed for infection control. 1. The facility failed to ensure CNA C doffed gloves after giving care to Resident #65 and #86 disposed of PPE properly on 08/19/2025. 2. The facility failed to ensure staff wore PPE while providing high contact resident care (transfers and medication administration through a gastrostomy tube) to Residents #29 and #70 on 08/21/2025. These failures could place residents at risk for infection, hospitalization, or death.Findings included: 1. Record review of Resident #65's face sheet, dated on 08/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included local infection of the skin and subcutaneous tissue, unspecified (a bacterial or fungal infection affecting a specific, limited area of the outer skin layers and the tissue beneath it), non-pressure chronic ulcer of skin of other sites limited to breakdown of skin (an open ,non-healing sore on the skin, not caused by prolonged pressure), and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (hemiplegia refers to paralysis- complete inability to move and hemiparesis - weakness). Record review of Resident # 65's admission MDS Assessment, dated 07/31/2025, reflected Resident #65 had a BIMS score of 10, which indicated her cognition was moderately impaired. Resident #65 had stage 4 pressure ulcer. Record review of Resident #65's Comprehensive Care Plan, dated 08/04/2025 reflected Resident #65 had stage 4 pressure ulcer to sacrum. The pressure ulcer was present upon admission. The care plan did not reflect Resident #65 being on contact precautions. 2. Record review of Resident # 86's face sheet, dated on 08/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident #86 had a diagnoses which included infection following a procedure, superficial incision surgical site, subsequent encounter (a bacterial or other microorganism infection that develops in the top layers of skin at a surgical wound site, rather than a deep one, for a resident receiving later follow-up medical care for the infection), methicillin resistant staphylococcus aureus infection, unspecified site (a common bacteria enter the body through a cut or wound, causing symptoms like red, painful, swollen areas, possibly with pus. Methicillin resistant- the bacteria has developed a resistance to certain antibiotics which are normally used to kill staph), and chronic pain (a long lasting, continuous, or recurring pain that persists for at least three months, beyond the normal healing time). Record review of Resident #86's Quarterly MDS Assessment, dated 07/26/2025, reflected Resident #86 had a BIMS score of 15 which indicated her cognition was intact. Resident #86 had open lesions and skin tears. She was receiving treatment for skin and ulcer/ injuries (non-surgical dressings and ointments) Record review of Resident #86's Comprehensive Care Plan, dated 08/08/2025, reflected Resident #86 was at risk for skin breakdown and pressure ulcer development due to decreased mobility and obesity. Resident #86 comprehensive care plan did not reflect Resident #86 being on contact isolation. 3. Record review of Resident #29's admission record, dated 08/21/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute and chronic respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood), tracheostomy status (a surgical opening in the neck directly to the breathing tube/trachea), hypotension (low blood pressure), gastrostomy status (a surgical opening directly to the stomach through the abdomen), nontraumatic intracerebral hemorrhage (bleeding within the brain without any external injury), and hemiplegia and hemiparesis (weakness and inability to move half of the body). Record review of Resident #29's medical record on 08/21/2025 reflected no submitted and accepted MDS due to Resident #29's recent admission on [DATE]. Record review of Resident #29's care plan, dated 08/19/2025, did not mention Enhanced Barrier Precautions Record review of Resident #29's order summary, dated 08/21/2025, reflected, Enhanced Barrier Precaution: PPE required for high resident contact care activities. Indication: TRACHEOSTOMY AND G-TUBE. 4. Record review of Resident #70's admission record, dated 08/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spina bifida (a birth defect that occurs when the neural tube, which forms the spine and spinal cord, does not close completely during early development in pregnancy), syndrome of inappropriate secretion of antidiuretic hormone (a condition where the body makes too much antidiuretic hormone causing water retention and low sodium levels), elevated white blood cell count (diagnosis can indicate infection, inflammation, or immune system disorders)

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	675118	A. Building B. Wing	08/21/2025

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Brush Country Nursing and Rehabilitation	6500 Brush Country Rd Austin, TX 78749

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review the facility failed to maintain essential kitchen equipment in safe operating conditions and according to manufacturers' specifications for the facility's one walk-in refrigerator and one walk-in freezer. 1. The facility failed to ensure that the walk-in freezer temperature was in safe operating conditions of 0 . 2. The facility failed to ensure the walk-in refrigerator's cooling fans were in safe operating conditions. These failures could place residents at risk for health complications, foodborne illnesses, and decreased quality of life. Findings include: Observation in the kitchen on 08/19/2025 at 4:37 PM revealed the walk-in freezer thermometer panel mount temperature was reading 3 . Observation in the kitchen on 08/20/2025 at 10:59 AM revealed the walk-in freezer thermometer panel mount temperature was reading 3 . Observation and interview in the kitchen on 08/20/2025 at 11:00 AM revealed a slow steady water leak from the bottom of the refrigerator cooling fans dripping into a large black plastic bin positioned directly underneath. CDM stated this was a new leak that has been reported to the maintenance staff for immediate repairs. She stated the black plastic bin is to keep the water from leaking onto the food stored on the shelf. She stated all packaged food was removed from this shelf temporarily awaiting repairs. She stated she believes the walk-in freezer temperature is above 0 as staff have been in and out of it this morning prepping foods for the day and organizing frozen foods. During an interview on 08/20/2025 at 1:13 PM, MAIN stated kitchen work orders are managed by him and one other staff. He stated he will reach out to 3rd party contractors if unable to make a repair himself, such as the walk-in refrigerator and walk-in freezer. He stated the leak was reported to him last week some time, the refrigeration contractor visited the facility last week to look at it. He stated there was a delivery last week and staff had the refrigeration doors open, and a lot of condensation was building up when the contractor was assessing. He stated the contractor recommended for him to look at adding some fans to the refrigerator, so it does not create condensation. He stated he also believed since the freezer doors were open for delivery it caused the temperature to rise. He stated kitchen staff are emptying the black plastic bin during morning and night shifts. He stated he has been researching how to run fans for the condensation build up, and he will have to put in electrical system to install the fans. He stated he looked at the inside of the refrigerator not draining. He said he was not sure about the water build up. He said he was looking getting air curtains for the doors. He stated he has requested invoices and estimates for this work. MAIN stated if water were to leak onto the stored food staff should not use as this could affect the residents and make them sick. Surveyor requested work orders submitted for temperatures and water leak concerns, invoices, and estimates from contractors regarding recommendations and repairs and recommended plan to repair the refrigeration systems. These items were not provided prior to exit. Observation on 08/21/2025 at 9:00 AM revealed the walk-in freezer thermometer panel mount temperature was reading 15 and the 2 dial freezer thermometer located in the walk-in freezer was reading 30 . Observation on 08/21/2025 at 9:07 AM revealed the walk-in freezer thermometer panel mount temperature was reading 15 and the 2 dial freezer thermometer located in the walk-in freezer was reading 18 . Observation and interview on 08/21/2025 at 9:11 AM revealed the large black plastic bin positioned directly underneath the cooling fans in the walk-in refrigerator was filled with dirty water that has leaked into it. CDM stated the black bin fills throughout the day and is dumped out every morning and evening shift. She removed the plastic bin to drain water, and the piping of the refrigerator was exposed and had rust and black tape wrapped around the hinges. Observation and interview on 08/21/2025 at 9:12 AM revealed the left side of the cooling fans also had a very slow leak and had dripped into the black large plastic bin that contained cheese blocks. The CDM stated the leak had not been a concern to the left side of the cooling fans and she was not aware of any additional leaks. During an interview on 08/21/2025 at 9:12 AM KH N stated she has been employed a year at this facility and the black plastic bin has been there the entire time and staff have been tasked with emptying out daily. She stated MAIN has been notified numerous times of this concern. She stated residents can become ill if the food is contaminated with leaking water. She stated all staff are responsible for reporting any faulty equipment to the CDM to submit work orders for repairs. During an interview on 08/21/2025 at 9:12 AM, CDM stated she has been employed at the facility since March 2025. She stated the MAIN has been notified numerous times of the walk-in refrigerator leak and walk-in freezer temperatures. She stated she has entered work orders in TELS (software to manage work orders), and MAIN would have access to these workorders. She stated this was a concern that the dietician had addressed with her during her last visit and quality assurance evaluation on 08/08/2025. She

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. (continued on next page)

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles, for 2 of 3 (SW, and Marketing) staff reviewed for training in Care Plans and PASRR services in that:The facility failed to train the Social Worker in the assigned SW areas in the PASRR, and updating the Care Plans for advance directives. The facility failed to train the Marketing person about ensuring a PASRR was received at admission.This failure could place residents at risk for harm by not having a complete and accurate care plan or having a PASRR completed to support the residents needs and preferences. The finding included:Resident #7 Review of Resident #7's face sheet dated [DATE] revealed an [AGE] year-old male who was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke), muscle weakness, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), lack of coordination, adjustment disorder, hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), repeated falls, cerebral infraction (long term effects of a stroke), and protein-calorie malnutrition (inadequate intake of both protein and calories). Review of Resident #7's quarterly MDS dated [DATE] revealed Resident #7 had a BIMS of 08 indicating moderate impairment. The MDS also did not have Resident #7's code status. Record review of Resident #7's care plan dated [DATE] revealed Resident #7 revealed that Resident #7 was a full code. Goal was Resident #7 would be provided with necessary resuscitative measures. Interventions were to advise MD, RP & family of any changes in condition per facility policy. Educate and discuss with resident/family about Full Code status versus OOHDNR code status on an annual basis or as needed. Review Advanced Directives with resident/family annually, upon change in condition andas needed. Record review of Resident #7's Advance Directive Order dated [DATE] revealed Resident #7 was a DNR. Record review of Resident #7's OOHDNR dated [DATE] had all the required signatures. Resident #17 Record review of Resident #17's admission sheet, dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including cystitis without hematuria (inflammation of the bladder), somatization disorder (tendency to experience and express psychological distress as physical symptoms), fusion of the spine (surgical procedure that connect two or more parts in the spine), muscle weakness, congenital malformation of nervous system (birth defect that affects the structure and development of the brain and spinal cord), lack of coordination, anxiety disorder (feeling of uneasiness or worry) and hypertension (high blood pressure). Record review of Resident #17's admission MDS assessment, dated [DATE], revealed Resident #17 had a BIMS score of 13, indicating intact cognitive response; mood indicators were present including little interest or pleasure in doing things, feeling down, depressed, or hopeless. The MDS also had somatization disorder (tendency to experience and express psychological distress as physical symptoms), and anxiety disorder (feeling of uneasiness or worry) as active diagnoses. Record review of Resident #17's care plan, dated on [DATE] noted the resident used an anti-anxiety medication r/t anxiety. The goal was that Resident #17 would be free from discomfort or adverse reactions related to anti-anxiety therapy. The interventions were Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucination. Record review revealed that Resident #17 did not have a PASRR completed. Resident #31 Review of Resident #31's face sheet dated [DATE] revealed an [AGE] year-old male who was admitted on [DATE] with diagnoses including muscle weakness, neurocognitive disorder with Lewy bodies (type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), anxiety (feeling of uneasiness or worry), hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), hyperlipidemia (high cholesterol), fall and anemia (not enough healthy red blood cells). Review of Resident #31's quarterly MDS dated [DATE] revealed Resident #31 had a BIMS of 12 indicating moderate impairment. The MDS also did not have Resident #31's code status. Record review of Resident