STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676267	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brodie Ranch Nursing and Rehabilitation Center	2101 Frate Barker Rd Austin, TX 78748

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals and included regular re-evaluation of residents to identify changes that require modification of the discharge plan and to reflect these changes in the discharge plan for one of one resident (Resident #1) reviewed for discharge planning. The facility failed to ensure Resident #1 had a discharge plan in place. This failure placed residents at risk of not having a plan in place to address residents post discharge needs. Findings included: Review of the undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body), cognitive communication deficit (problems with communication caused by cognitive impairment), aphasia following cerebral infarction (loss of speech following a stroke that cause death of brain tissue), and depressive episodes. Review of the admission MDS for Resident #1 dated 04/03/24 reflected a BIMS score of 13, indicating intact cognition. Review of the care plan for Resident #1 dated 04/03/24 reflected Wishes to stay in the facility for long term care. Discharge goals are: stay in the facility for long term care. Establish a pre-discharge plan with the resident, family/caregivers and evaluate progress and revise plan as needed. Review of the progress notes for Resident #1 from 03/27/24 to 05/22/24 reflected no notes pertaining to discharge planning or transfer to another NF. Review of documents in Resident #1's electronic medical record reflected no documents related to discharge planning or transfer to another NF. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/22/24 at 02:14 PM revealed Resident #1 in his room calling out to the surveyors as they passed by his open door. He was in his wheelchair, and he could not speak clear words but had a laminated page of letters attached to his wheelchair. Using his finger to point at letters and spell words, he stated that he wanted to move to a specific local nursing facility. He stated he had told people at the facility he wanted to move, but they had done nothing and had not spoken with him to update him on their progress. During an interview on 05/22/24 at 04:10 PM, the SW stated she was doing some discharge planning for Resident #1, and his family did not want him to transfer. She stated she had reached out to the other facility, and they had not answered or returned her phone calls until this afternoon. She stated she planned to reach out to the family before she sent any clinical documents/referral paperwork to the other facility. She stated she did not know if Resident #1 needed to have his family involved in his decision-making. The SW stated she would have to look at his chart for cognitive status and medical power of attorney. She stated if there was a medical power of attorney in place, she would have to consult that person. The SW stated she did not know he had a BIMS score of 13 and was his own responsible party. She stated she did not know his family members were only listed as emergency contacts in his profile. She stated she had not discovered that information yet, because she had not been able to contact the facility where he wanted to move. The SW stated she now had an email where she could send the referral. She stated she had been working on it. The SW stated her caseload for residents who were actively discharging was around 8 to ten, and that was not a huge caseload. She stated Resident #1 expressed his desire to move to the other facility about a month ago. She stated she had not documented any of her efforts to reach the facility he desired to move to on the EMR, but she had a notebook where she documented each time she contacted the facility where he wanted to move . The SW stated she had visited with Resident #1 every other week about her progress. The SW stated she visited him today at 03:40 PM to update him. The SW stated a potential negative impact of not having discharge planning under way was, theoretically, a resident would feel his wants were not being addressed. She stated it was important to develop and implement discharge planning because it was the resident's right, and they should have had the opportunity to move if they wanted to move. During observation and interview on 05/22/24 at 04:27 PM, the DON provided an electronic tablet with a note-taking application open and a note titled with Resident #1's name on the screen. The note had a date of 05/22/24 and had several marginally legible handwritten electronic notes indicating dates and times of phone calls made to the facility where Resident #1 wanted to move. During an interview on 05/22/24 at 04:43 PM, the ADM stated he found out from Resident #1 that he wanted to move to another facility a couple weeks ago and told the SW about it. The ADM stated he was not sure if Resident #1 was pending Medicaid and had not been approved yet, but he thought that might be the hang up and the reason why the referral had not been initiated. The ADM stated he would think the SW would have made a note in the EMR when she reached out to the other facility. The ADM stated he stops and sees Resident #1 frequently, because Resident #1 was on his morning rounds. The ADM stated usually the issues Resident #1 had were that he was missing something or some small problem. The ADM stated the SW's perception may have been that the resident's FM is at the facility often, has a lot to say about his care, and is somewhat hovering so the SW may have assumed the FM would be making the decisions for Resident #1. The ADM stated that was not the facility policy, and the discharge planning should have been initiated and documented. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy dated 11/2016 and titled Discharge Planning Process reflected the following: It is the policy of the facility that the discharge planning process focuses on the resident's discharge goals, involving the residents as active partners. The discharge process should effectively transition them to post-discharge care, and minimize clinical or other factors which are related to the possibility of readmission. 1. The Facility's discharge planning process shall: a. Provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the Facility. f. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. If participation by the resident and the representative is determined not practicable for the development of the resident's discharge plan, an explanation shall be documented in the resident's medical record. 2. For residents who were transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, the facility shall assist residents and their resident representatives in selecting a post-acute care provider by using data that includes but is not limited to a. SNF, HHA, or LTCH standardized patient assessment. b. Data on quality measures; and, c. Data on resource used to the extent the data is available. 4. The facility shall document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.